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# College In Mind: A Mixed-Methods Study Of How Emerging Adults With Psychiatric Disabilities Prepare For And Transition To And Through Higher Education

Laura Carolyn Murray
*University of Pennsylvania*, lamurray@gse.upenn.edu

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# College In Mind: A Mixed-Methods Study Of How Emerging Adults With Psychiatric Disabilities Prepare For And Transition To And Through Higher Education

**Abstract**
This dissertation study employs an exploratory sequential mixed methods design to investigate how emerging adults with psychiatric disabilities plan for and transition to and through college. Special attention is paid to how disclosure of disability status in educational contexts can influence both educational and recovery outcomes. Though more students with psychiatric disabilities attend American colleges and universities than ever before (Gallagher, 2014), little is known about their educational experiences prior to arrival in higher education or the strategies they employ to navigate college once there. Taking a strengths-based approach grounded in disability theory, the study conceives of college as a realistic goal for many, as well as a potentially powerful context for continued recovery and optimal development.

The study investigates how students with mood, anxiety, and psychotic disorders matriculate into college and persist in pursuing educational and personal goals. Qualitative data consists of multiple semi-structured interviews with each of 26 participants, and quantitative data consists of surveys completed by 22 of these participants, as well as 56 additional anonymous respondents (total n = 78).

Interviews were analyzed through a process informed by grounded theory (Glaser & Strauss, 1967), leading to the emergence of three key theoretical constructs representing essential processes in successful college transitions for students with psychiatric

disabilities: (1) Strategically Disclosing Aspects of Mental Health; (2) Constructing a Recovery Identity; and (3) Participating in College and Experiencing Social and Academic Integration on Campus. An over-arching grounded theory of Education for Rehabilitation, is then proposed, marrying the above individual-level findings with institutional-level recommendations to better support students' recovery and educational journeys.

Next, an online survey informed by the above qualitative findings was developed to further investigate college transition experiences with a larger sample. Items address respondents' diagnoses and treatment histories; high school experiences; choices

surrounding mental health disclosures in educational contexts; college planning and application activities; and use of academic accommodations in higher education. The survey also includes measures of institutional integration in college (IIS, French & Oakes, 2004), self-perceived recovery (RAS, Corrigan et al., 1999; Corrigan et al., 2004), and a new pilot measure of disclosure. Over-all level of mental health disclosure in college is significantly greater than over-all level of disclosure in high school. In addition, disclosure in college is significantly and positively correlated with IIS and RAS total scores, as well as with use of on-campus counseling services. Implications for

supporting students' "strategic disclosures" in order to promote recovery as well as social and academic integration in educational contexts are explored.

Ultimately, qualitative themes are merged with select quantitative findings to paint a nuanced picture of the experience of college preparation, transition, and ongoing recovery for students. Recommendations to inform policy and practice at both the individual and institutional levels are proposed, and a call for change, or

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rehabilitating higher education to better support integrated learning and recovery for students with psychiatric disabilities is made.

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# COLLEGE IN MIND: A MIXED-METHODS STUDY OF HOW EMERGING ADULTS WITH PSYCHIATRIC DISABILITIES PREPARE FOR AND TRANSITION TO AND THROUGH HIGHER EDUCATION

Laura Carolyn Murray

A DISSERTATION

in

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Presented to the Faculties of the University of Pennsylvania

in

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2017

Supervisor of Dissertation:

_____

Howard C. Stevenson, Constance Clayton Chair in Urban Education

Graduate Group Chairperson:

_____

J. Matthew Hartley, Professor of Education

Dissertation Committee:

Howard C. Stevenson, Constance Clayton Chair in Urban Education

Michael J. Nakkula, Practice Professor of Education

Mark Salzer, Professor of Rehabilitation Science, Temple University

COLLEGE IN MIND: A MIXED METHODS STUDY OF HOW EMERGING ADULTS WITH PSYCHIATRIC DISABILITIES PREPARE FOR AND TRANSITION TO AND THOUGH HIGHER EDUCATION

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*Dedication*

This dissertation is dedicated to the many wonderful young women and men who graciously shared their lives and stories with me. Your commitment to your own growth and recovery while working toward your educational and career goals is truly inspirational. In addition, your willingness to be so candid and honest in your interviews - all in an effort to help pave the way for other young people to follow in your footsteps - has been truly humbling. I cannot thank you enough for the time that you gave to me and to this study, and I sincerely hope that this manuscript can reflect at least a small fraction of the beauty and power of your stories, as well as your capacity to thrive in the face of sometimes profound challenges. I also hope that I can share a bit of your irrepressible senses of humor, as well as the deceptively simple message that so many of you insist upon: you have a right to an education that works for *you.*

As the late, great, Maya Angelou once said, "My wish for you is to continue. Continue to be who and how you are." Because you are all *extraordinary.*

This dissertation is also dedicated to the memory of John Anthony (aka "Handsome Jack") Murray: English teacher, high school principal, football coach, beloved husband, father, and grandfather – and my one and only "Pop." You are always with me.

## ACKNOWLEDGMENTS

While writing a dissertation can often feel like the most isolating of activities, I was never truly alone. This work is the cumulative result of many, and I am grateful to all of you. I have been given constant support and encouragement from family, friends, colleagues, mentors, and even (and especially!) my study participants. I thank you all.

To my family: I cannot begin to express my gratitude to all of you for your willingness to ask just enough about my work to convince me of your interest and support, while affording me the time, space, and long stretches of uninterrupted quiet to think, read, fret, analyze, walk the dogs, and write.

First, I must express deep gratitude to my parents, Donna and Frank Murray. I so appreciate your lasting commitment to learning, your unconditional love, and your acceptance of me - even when at my "most intense." Mom, you were my very first and best teacher, patiently reading all of my favorite books (*Little Blue Jack*, *Travelling to Tripiti,* and the *Berenstain Bears* anthology) over and over again while offering limitless art supplies, trips to the zoo, tea parties, and music lessons. You magically (strategically?) created the optimal mix of autonomy and support for one exceedingly precocious little girl. And for that, I am forever grateful. And Dad, you are the greatest *Scrabble* player I know, and also by far the greatest man. In addition to the incredible love and care that you give to all of us in the family, you also inspire your own crop of students every year, and continue to vividly model what an exemplary educator can be. You are curious, energetic, and funny while always displaying an honest and deep commitment to teaching and a sincere care for your students' growth both in the

classroom and beyond it. Mom and Dad, I love you both immensely.

Lyndsay, you are the most marvelous sister anyone could ever hope for, and the person with the straightest, clearest, and most stunning moral compass of anyone I know. Thank you for teaching me how to be a big sister, a "built-in babysitter," a compassionate human being, and soon, a mom.

Mamo and Tato Stawnychy, thank you for accepting me with open arms into the Stawnynchy clan not simply as your "daughter-in-law," but as, simply, your "daughter." Your generosity, support, family vacations, and world-class holiday feasts over the years have taught me so much about Ukrainian culture, but even more about family, loyalty, and love.

And Misho, you continue to amaze me with your kindness, generous spirit, creative genius, ability to engage just about anyone in meaningful conversation, and capacity to not just *talk* about doing good in the world but to actually *do* it. You are my magnificent partner in love, learning, and in life, and I can't imagine having left California to drive across the country in a rented RV to start anew in Philadelphia with anyone else. In fact, I am quite certain that I am here today entirely because of you.

I believe that research, like learning and development more broadly, is always relational. With this in mind, I'd like to take a moment to acknowledge the particular people who helped to bring this dissertation to fruition. First, a hearty and heart-felt "thank you" to my distinguished committee members and mentors: Dr. Howard Stevenson, Dr. Mark Salzer, and Dr. Mike Nakkula. Howard, you exemplify deep knowledge merged with deep purpose, and I aspire to emulate your work putting

powerful ideas into action to improve young people's lives. I hope to become the type of researcher, teacher, and mentor that you are, and to have just a fraction of the profound and positive affect that you have had on so many children and families – and graduate students! And Mark, you are not only a brilliant and prolific scholar whose psychiatric rehabilitation work helps countless people every day, you are also one of the most kind, generous, and humble people I have had the pleasure of meeting. I am truly honored to know you, I have profound respect for your scholarly work, and I am humbled by the time and support you have afforded me as I transition into this next phase of my career.

And, Mike, what can I say? You are truly the greatest advisor that anyone could ever have, and I am quite certain that although I have Misho to thank for landing me here in Philadelphia, I have you to thank for keeping me here. You have nurtured my thinking, my writing, my teaching and my over-all intellectual and professional growth. Simply put, you have launched me into this next chapter and prepared me to fly. I also have you to thank for offering me so many opportunities to work with you, collaborate on research, and to learn to teach - as your student, your TA, and then, independently (with plenty of scaffolding). You are not only an exceptional model for how to be a teacher, researcher, counselor, advisor, and educator….you are a genuine template for how to be a kind and compassionate person. I learned about human development not just from you, but *with* you, and I believe that I am (we are) forever changed for the better.

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(formerly Slaughter-Defoe), you were my first advisor at Penn GSE, and although the school "lost" you to a well-deserved retirement, I have happily not "lost" you at all. I remain profoundly grateful to have you as role model, friend, and cross-country confidant. You remind me of what it is to be a woman and a scholar – while also reminding me to enjoy life, be spontaneous, appreciate art, travel as widely and often as possible, and to always be open to the unexpected – even to love and marriage after age 70!

And to Dr. Vivian Gadsden – you are my neighbor, my friend, and a much-loved mentor. Your soft-spoken demeanor belies your commanding scholarship, and your approachability and deep care for students is nothing short of remarkable given your busy role on the national stage (yes – the President of the AERA lives down the block from me.) I so appreciate having had you as a professor, and also having had the gift of being a teaching assistant with you. But I think that I appreciate our sidewalk chats as I walk my dogs past your house most of all.

And to Dr. Caroline Watts, after you visited my Human Development Pro-Seminar class in the Fall of 2009 to speak about your work, and before I really knew you, I remember thinking, "I want to do what *she* does." What you do, and your passion for it, have both made deep impressions on me. In addition, your course "School, Community, and Mental Health Partnerships," has in many ways laid the foundation for my continued scholarship. You and Mike truly are what I like to call "the dynamic duo," and I am so fortunate to have you both in my life.

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I would also like to thank my dear friends Katie and John Cadigan, who truly taught me what love, family, and recovery can and should look like. You are two of the primary reasons that I do the work that I do today, and I will always hold you in my heart.

And most importantly, I wish to acknowledge the 78 young adults who took the time to complete my (very long!) online survey. Your participation, candor, and reflections regarding your experiences are inspiring. In addition, I would like to offer an impassioned and enthusiastic "thank you" to the young adults who participated in the interview arm of this study. You met with me during busy college days and spoke with me openly and thoughtfully about very personal - and sometimes painful - experiences regarding serious mental illness while also embodying hope, resilience, persistence, and recovery. You all shine a light on what it means to "live and learn," and you motivate and inspire me to continue this work to assist youth and young adults to not just survive, but to *thrive* - to not just *meet* educational and personal goals, but to exceed them. You all truly are the experts, and I am honored to know each and every one of you.

And, finally, I want to clarify that any and all mistakes in this document are entirely my own, and that any strengths and insights are definitely due to the perfectly imperfect people and the wonderfully fulfilling relationships and collaborations noted above.

## ABSTRACT

COLLEGE IN MIND: A MIXED-METHODS STUDY OF HOW EMERGING ADULTS WITH PSYCHIATRIC DISABILITIES PREPARE FOR AND TRANSITION TO AND THROUGH HIGHER EDUCATION

Laura C. Murray

Michael J. Nakkula

This dissertation study employs an exploratory sequential mixed methods design to investigate how emerging adults with psychiatric disabilities plan for and transition to and through college. Special attention is paid to how disclosure of disability status in educational contexts can influence both educational and recovery outcomes. Though more students with psychiatric disabilities attend American colleges and universities than ever before (Gallagher, 2014), little is known about their educational experiences prior to arrival in higher education or the strategies they employ to navigate college once there. Taking a strengths-based approach grounded in disability theory, the study conceives of college as a realistic goal for many, as well as a potentially powerful context for continued recovery and optimal development.

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Interviews were analyzed through a process informed by grounded theory (Glaser &

Strauss, 1967), leading to the emergence of three key theoretical constructs representing essential processes in successful college transitions for students with psychiatric disabilities: (1) *Strategically Disclosing Aspects of Mental Health;* (2) *Constructing a Recovery Identity*; and (3) *Participating in College and Experiencing Social and Academic Integration on Campus.* An over-arching grounded theory of *Education for Rehabilitation,* is then proposed, marrying the above individual-level findings with institutional-level recommendations to better support students' recovery *and* educational journeys.

Next, an online survey informed by the above qualitative findings was developed to further investigate college transition experiences with a larger sample. Items address respondents' diagnoses and treatment histories; high school experiences; choices surrounding mental health disclosures in educational contexts; college planning and application activities; and use of academic accommodations in higher education. The survey also includes measures of *institutional integration* in college (IIS, French & Oakes, 2004), self-perceived *recovery* (RAS, Corrigan et al., 1999; Corrigan et al., 2004), and a new pilot measure of *disclosure*. Over-all level of mental health disclosure in college is significantly greater than over-all level of disclosure in high school. In addition, disclosure in college is significantly and positively correlated with IIS and RAS total scores, as well as with use of on-campus counseling services. Implications for supporting students' "strategic disclosures" in order to promote recovery as well as social and academic integration in educational contexts are explored.

Ultimately, qualitative themes are merged with select quantitative findings to paint a

nuanced picture of the experience of college preparation, transition, and ongoing recovery for students. Recommendations to inform policy and practice at both the individual and institutional levels are proposed, and a call for change, or *rehabilitating higher education* to better support integrated learning and recovery for students with psychiatric disabilities is made.

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# CHAPTER 1

# INTRODUCTION

The current study examines how recent high school graduates with psychiatric disabilities plan for and make the transition to college, paying special attention to how decisions surrounding disclosure of their disability status can influence social and educational outcomes in college. Discussion in this chapter is organized in the following sections: (1) overview of the issues; (2) purpose of the study; (3) rationale for and significance of the study; (4) the research questions; (5) researcher goals, reflexivity, and positionality; (6) overview of methodology and explanation of the type of mixed methods design employed; (7) a synopsis of the organization of this dissertation; and (8) definition of terms.

## Overview of the Issues

In decades past, a dearth of effective treatments too often kept young people with psychiatric disabilities from pursuing higher education; fortunately, recent medical advances coupled with better social supports and a growing public understanding of mental health allow more students with mental illness to attend college than ever before (Gallagher, 2014). Despite the prevalence of disorders such as depression, anxiety, bipolar, and schizophrenia on college campuses, however, research on educational trajectories and experiences for these students is limited. Little is known about students' experiences on college campuses, with even less known regarding their educational trajectories prior to college admission (American College Health Association, 2013). They remain, in many ways, a large yet hidden population on American campuses.

By understanding what has both hindered and facilitated college transitions for youth and young adults with psychiatric disabilities, we might provide more effective educational supports, with the ultimate goal of more young people entering and completing college ready for meaningful and productive careers, independent adult lives, and fulfilling social relationships.

One in four Americans will be diagnosed with a mental illness in his or her lifetime, and roughly half of all mental health disorders start by age fourteen (Gould, Greenberg, Velting & Shaffer, 2003; Kessler, Berglund, Demler, Jin, & Walters, 2005; Kessler, Amminger, Aguilar-Gaxiola, Alonso, Lee, & Ustun, 2007). Twenty percent of youth ages 0-18 meet the criteria for a diagnosable mental health disorder (U.S. Department of Health and Human Services, 1999), and conditions such as anxiety and depression are some of the most prevalent and challenging threats to healthy youth development.

Mental health disorders in young people pose a major threat to school success because students with mental health challenges who do not receive adequate services and supports are at heightened risk for school dropout. Students with emotional disturbance (ED), in fact, have lower grades and higher dropout rates than any other group of students with disabilities (Newman et al., 2011). And among students who do not complete high school in general, a full 59% are students with emotional and behavioral disabilities (Blackorby & Wagner, 1996; Vander Stoep, Weiss, Saldanha, & Cohen, 2003). Even youth with psychiatric disabilities who *are* able to complete high school face diminished odds of attaining employment and increased odds of incarceration (Egyed, McIntosh &

Bull, 1998; Nolan, 2011). In addition, of those who matriculate into institutions of higher, 86% dropout of college without completing a degree (Kessler, Foster, Saunders, and Stang, 1995). This is nearly twice as high as the general college dropout rate, which is estimated to be approximately 44% (Symonds, Schwartz, & Ferguson, 2011). Even among other college students with disabilities, students with psychiatric disabilities are the *least likely of all groups* – including developmental, learning, and physical disabilities – to persist in college (Newman et al., 2011).

The majority of existing literature on adolescents and emerging adults with psychiatric disabilities emphasizes the myriad challenges that this population faces, as well as negative outcomes that are all too common (Eisenberg, Golberstein, & Hunt, 2009; Pleskac et al., 2011). Indeed, the conspicuous absence of more stories of recovery and achievement in educational domains seems to highlight the flawed assumption that higher education is out of reach for people living with mental illness.

**Purpose of the Study**

The primary purpose of this study is to explore and describe the experiences of emerging adults with psychiatric disabilities as they plan for and transition to and through higher education. A secondary purpose is to investigate whether and how decisions related to psychiatric disability disclosure shape students' social and academic integration on college campuses. And, finally, a tertiary purpose is to examine possible relationships among disclosure, institutional integration, and students' sense of recovery in educational contexts.

A longitudinal exploratory mixed methods design is used, with qualitative data collected at two points in time over the course of an academic year, and quantitative data

collection in the interim and informed by the initial round of qualitative data. In the first, qualitative phase of the study, semi-structured interviews were conducted with 26 young adults with psychiatric disabilities attending fourteen different 2- and 4-year U.S. colleges and universities. These interviews explore participants' college preparation and transition experiences. The second, quantitative phase of the study consisted of creating and implementing an online survey with a larger sample to develop a more comprehensive understanding of college transitions for this population, as well as to test the hypothesis that higher levels of psychiatric disability closure are positively associated with institutional integration and self-perceived recovery. And, finally, the third and final (qualitative) phase of the study entailed follow-up interviews with 22 of the original 26 interview participants in order to assess their college transition experiences over time.

Note that this study assumes that in order for students with psychiatric disabilities to seek mental health and academic services and supports, and/or to experience a sense of "integration" in college, they must first make choices regarding whether and how to tell others about their mental health status.

**Rationale and Significance**

There appears to be a major disconnect between the relatively rich literature-base on secondary school students with disabilities and "transition planning" for life after high school (Ellison, Rogers, & Costa, 2013; Hovish et al., 2012; Maag & Katsiyannis, 1998; Wagner & Davis, 2006; Wagner & Newman, 2012), and the limited literature regarding what actually happens when - and if - students with disabilities enter the college environment. In addition, although there is burgeoning literature on the experiences of college students with mental illness *once they are in college* (Belch, 2011; Knis-

Matthews, Bokara, DeMeo, Lepore, & Maus, 2007; Markoulakis & Kirsh, 2013; McEwan & Downie, 2013; Padron, 2006; Salzer, 2012; Salzer, Wick, & Rogers, 2008; Stein, 2012, 2013, 2014; Weiner, 1999; Weiner & Weiner, 1996**)**, information regarding the experiences of young people with psychiatric disabilities prior to matriculation, as they aspire to, investigate, and plan for higher education, is lacking. In addition, no longitudinal studies of college transitions for this population exist. The limited longitudinal work related to college student mental health is quantitative and focuses on young adult experiences once in college (Eisenberg, Hunt, Speer, & Zivin, 2011; Eisenberg & Lipson, 2015; Gallagher, 2014), leaving secondary school and college preparation experiences largely unexplored.

The current research is the first longitudinal and mixed-methods study of students' experiences regarding managing psychiatric disabilities while transitioning to and through higher education. The study contributes new knowledge to the growing body of literature related to higher education for emerging adults with serious mental illness, as well as to an understanding of issues relevant to students with disabilities more broadly. In addition, the college planning processes that are specific to this population are examined. Currently, first-person accounts from youth living with psychiatric disabilities regarding their high school and college preparation experiences are entirely absent from the literature. The current study can begin to fill this gap.

In addition, the solid research base on college transition, integration, and attrition, is augmented by this study's focus on the sub-group of students currently least likely to graduate from high school and most at-risk to dropout of college: students with mental

illness (Eisenberg, Golberstein, & Hunt, 2009; U.S. Dept. of Education, 2005; Vander Stoep et al., 2003).

Findings from this study broaden the scope of recent work related to disclosure for people with "concealable stigmatized identities." There is a vast body of work related to "coming out" for adult and youth members of the LGBTQ community. In addition, several recent publications explore disclosure for young people who are HIV positive (Calabrese et al, 2012; Gillard & Roark, 2013; Lam, P. K., Naar-King, S. & Wright, K., 2007; Toth, Tucker, Leahy, & Stewart, 2014). Very few publications, however, address disclosure for youth or young adults with psychiatric disabilities and only six have been identified that specifically include discussion of students' mental health disclosures in educational settings (Colognori et al., 2012; Corrigan et al., 2015; Kranke, Jackson, Taylor, Anderson-Fye, & Fleorsch, 2013; McAuliffe, Boddy, McLennan, & Stewart, 2012; Venville, Street, & Fossey, 2014; Venville & Street, 2012). Disclosure of one's psychiatric disability in an educational setting holds implications in both academic and social realms. For example, choices surrounding "coming out" can influence whether a student accesses needed academic accommodations at a college's Office of Disability Services; whether and how she or he makes and maintains new friendships; and if a group of peers with similar disabilities can be identified and joined for targeted social support.

And, finally, in order to promote learning and optimal development for all students, institutions must acknowledge the growing population of students with mental illness; a necessary first step is to listen to students' stories and to learn from them. Here, my approach is intentionally strengths-based, with a goal of foregrounding the voices and

stories of youth and young adults who are often marginalized and absent from the literature. How students with serious mental illness conceive of higher education, plan for college entrance, transition to and through higher education, and make meaning of their lives in educational contexts holds theoretical implications for adolescent and emerging adult development, as well as practical significance for (1) higher education administrators, faculty, and staff serving college students with psychiatric disabilities; (2) parents and secondary school educators helping youth to prepare for successful transitions to higher education; (3) youth-serving and mental health organizations assisting clients in the pursuit and attainment of college degrees; and (4) aspiring students with mental illness striving for college success.

**Initial Research Questions**

RQ #1: What is the process of preparation for and transition to and through higher education for young adults with psychiatric disabilities (PDs)?

Sub-questions:

1.a How do adolescent high school students with PDs prepare for college?

1.b What are these students' experiences of social and academic integration in college over time?

RQ #2: To whom and why do youth and emerging adults (EAs) with PDs make mental health disclosures in educational contexts?

Sub-questions:

2.a. Do these decisions change as students move from high school to college?

2.b. What are others' reactions to students' mental health disclosures in college?

RQ #3: What are the relationships among disclosure, institutional integration, and recovery for EA college students w/ PDs?

Sub-questions:

3.a. Does psychiatric disability disclosure in high school predict disclosure in college?

3.b. Does psychiatric disability disclosure to college peers predict disclosure to college faculty?

3.c. Does psychiatric disability disclosure to college peers predict use of campus-based counseling or psychological services?

3.d. Does psychiatric disability disclosure to college peers predict use of Student Disability Services on campus?

3.e. Is psychiatric disability disclosure in college associated with institutional integration (IIS)? And IIS subscales?

3.f. Is psychiatric disability disclosure in college associated with subjective experiences of recovery (RAS) ? And RAS subscales?

3.g. Is institutional integration associated with recovery?

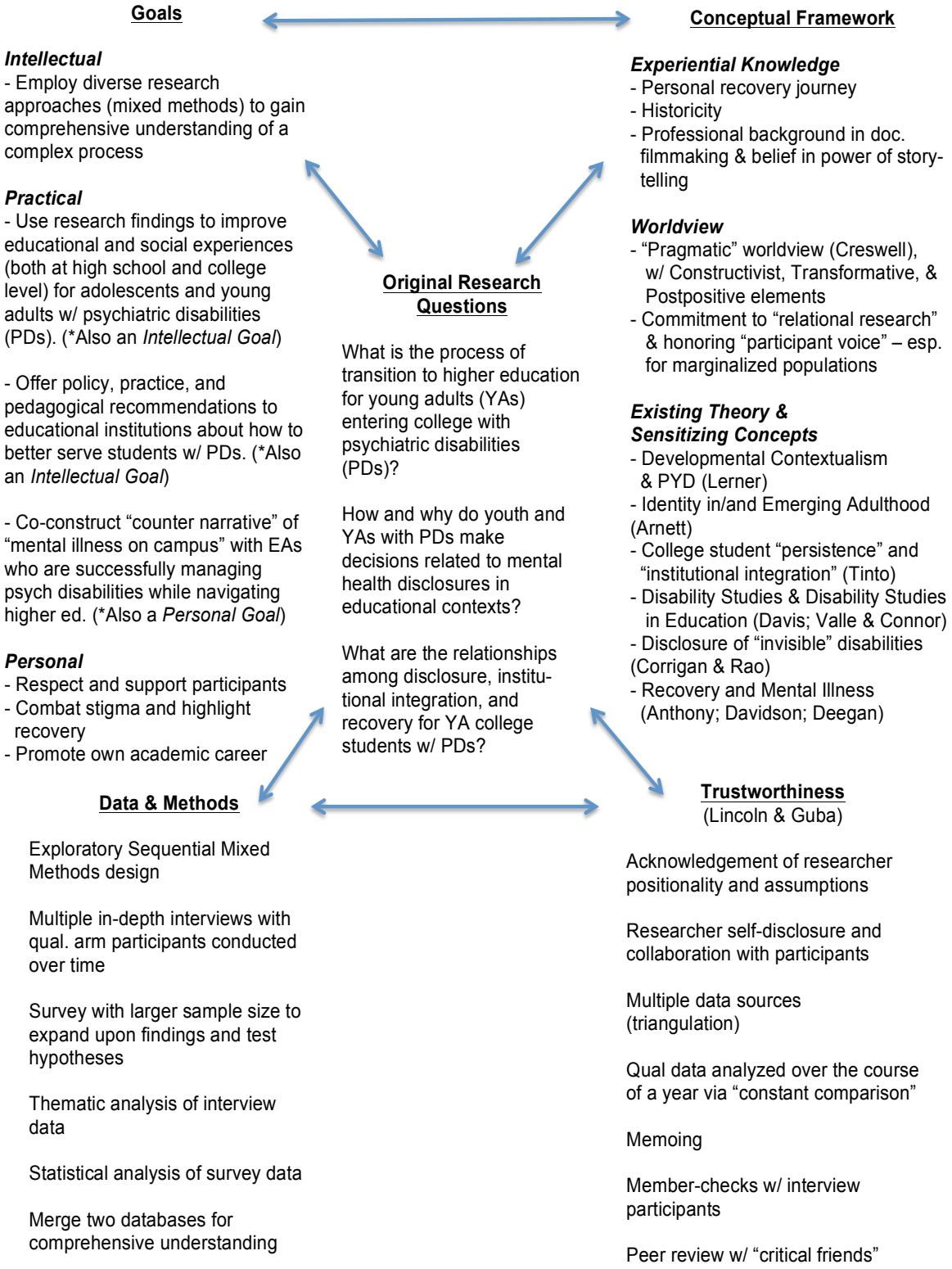
**Researcher Goals, Reflexivity, and Positionality**

Taking a cue from Maxwell (2005), I offer a general model for this entire study on the following page (see Figure 1.1). I adapt Maxwell's template to think through four key components of this research study: my goals as a researcher, the conceptual framework that undergirds the study; what Lincoln and Guba (1985; 1986) call "trustworthiness" in research; and the basic choices that I have made regarding data

sources, collection, and interpretation. These four components interact and inform my three original three research questions, above.

While I extrapolate on issues related to data, methods, and "trustworthiness" in Chapter Four (*Research Methodology and Design*) and dedicate all of Chapter Two to describing the conceptual framework for the study, below I address my goals for this research. I follow this with a discussion of my position in relation to the work and the study participants, and end with a justification and explanation for my choice to employ mixed methods.

**Figure 1.1** General Research Model for this Dissertation (adapted from Maxwell, 2005, p. 9)



**Researcher goals**

Maxwell (2005) reminds us that, whether made explicit or not, all researchers have personal, practical, and intellectual goals. In his definition, a research goal includes "motives, desires and purposes – anything that leads you to do the study or that you want to accomplish by doing it" (p. 15). Personal goals are those that motivate a researcher to conduct a particular study, and these goals may or may not be important to others. Practical goals are "focused on *accomplishing* something - meeting some need, changing some situation, or achieving some objective," while complementary intellectual goals "are focused on *understanding* something – gaining insight into what is going on and why this is happening, or answering some question that previous research has not adequately addressed" (p. 21). Maxwell advocates ongoing and thoughtful consideration of these various and sometimes intersecting goals in order to maintain clarity, integrity and rigor throughout one's research process.

> (Y)our goals inevitably shape the descriptions, interpretations, and theories you create in your research. They therefore constitute not only important resources that you can draw on in planning, conducting, and justifying the research, but also potential validity threats, or sources of bias for the research results that you will need to deal with. (Maxwell, 2005, pp. 15-16).

Here, I discuss my own goals for this study in an effort to be candid and transparent. These goals, like the conceptual framework described in Chapter Two, guide the methodological choices I make and are deeply linked to the findings that I draw.

**Intellectual Goals.** My over-arching intellectual goal is to merge diverse research approaches in order to gain a more comprehensive understanding of the complex phenomenon of college preparation and transition for emerging adults (Arnett, 2004) with psychiatric disabilities. As a corollary, I am interested in interrogating (and

transcending?) an either/or biomedical versus social approach to psychiatric disability and recovery. In both my methods and my choice of phenomena to study, I intend to move beyond dichotomous thinking and acknowledge the practicality of seemingly conflicting concepts and approaches.

I have two additional intellectual goals that also double as practical goals: (1) I intend to use this research and its findings, grounded in the experiences of real students as they navigate the contemporary American educational system, to improve educational experiences for youth and emerging adults with psychiatric disabilities, and (2) I hope to offer policy, practice, and pedagogical recommendations to both secondary schools and educational institutions regarding how to better serve and support these students. For me, a primary purpose of social science research is to identify and create evidence-based practices that can inform programs, interventions, policy, and legislation - all in an effort to improve people's lives. I am committed to real-world applications of empirical findings.

**Personal and Practical Goals.** Both personally and practically, my intent was and remains to work collaboratively with participants to co-construct a counter-narrative to sensationalistic headlines regarding "mental illness on college campuses." In many ways, this study was conceived as a reaction to two of the most common media and scholarly tropes related to youth and young adults with mental health challenges in schools today: (1) school failure (and related associations with homelessness, arrest, and incarceration); and (2) the potential for school violence (school shootings, homicides, and student suicides). Instead, I intend to give voice to an often silenced and marginalized population of students by sharing real-world examples from study participants' lives that

complicate the picture of psychiatric disability in educational contexts. What about counter-narratives that highlight students who are doing *well* academically, for example? What about college students who have returned to school after multiple hospitalizations and are persisting toward their degrees? And what about adolescents and young adults sharing their own stories publically to combat stigma and quell misunderstanding of mental illness and related discrimination on their own campuses?

Instead of a focus on deficits and pathology, and instead of defaulting to an emphasis on negative outcomes, my intention has been to humbly work with study participants (the true experts regarding their lives) to collectively construct strengths-based counter-narratives. By reframing youth and young adult educational experiences in a way that emphasizes recovery, resilience, and self-determination, a more accurate and authentic picture of managing psychiatric disabilities *while* navigating higher education (not instead of or apart from it) may emerge.

And, finally, I cannot deny that I also hold the personal goal of furthering my own scholarly work and career.

**Reflexivity and Positionality**

Reflexivity is the process of reflecting critically on one's role as researcher. Heppner, Wampold, and Kivlighan (2008) explain that reflexivity "is the conscious experiencing of the self as both inquirer and respondent, as teacher and learner, as the one coming to know the self within the processes of research itself" (p. 124). Interrogating my own evolving position as researcher is a necessary part of this study, and I have considered this at the proposal writing stage of the study, throughout data collection and analysis, and now, as I write up findings.

Where I sit, metaphorically, informs my research methods, questions, and every aspect of my interactions with study participants. I am not objective, and I view this as a strength. Indeed, I have my own lived experience of mental illness and recovery, and I believe that I owe much of my scholarly interest in youth and young adult development and mental health to this personal history. I believe that my "position" in this study, which combines personal experience and sensitivity with theoretical awareness and scholarship, makes me both insider *and* outsider, and that this is beneficial.

I recognize that I differ from my study participants in numerous ways - and that they differ from each other - but I also recognize and value what we share in common. We are a generation apart, the study participants and I, and their experiences in high school and college were and remain worlds away from mine. They look at me quizzically when I explain that there was no internet when I entered college in 1991, and that we were years away from smart phones, let alone texting; and they sigh disapprovingly when I am honest about my preference for talking on the phone versus chatting via Skype.

Yet when I tell them about first stepping off a hospital elevator and into a pediatric psychiatry ward as a 14 year-old patient, they nod in understanding. In this way, we are the same. We have all had unique experiences, of course, but we share a common history, too, and are fluent in a sort of shorthand of mental illness in adolescence that affords us collective insight, camaraderie and an unshakable bond.

**A disclosure about personal disclosure.** I decided to disclose my own history of mental illness and recovery to the potential participants in this study during the recruitment phase. I made this decision thoughtfully and strategically, and chose to

mention my past in order to explain my interest in and commitment to the research topic. In addition, I viewed this disclosure as a way to level the metaphorical research playing field by mitigating the inherent power differential between researcher and study participants. And, finally, I believed that telling the interview participants about my own eating disorder and depression would model the type of honest and candid conversation in a comfortable and confidential research space that I hoped to continue to have with them.

During the first phone conversation I had with potential interview participants, and prior to them consenting to participate, I simply said "I think you should know that I had anorexia and depression in high school. Fortunately, I recovered from my eating disorder and have not had a relapse; however, depression is something that I have been living with and managing for many years. This history is very much at the root of my interest in youth mental health." I did not divulge specific details of my symptoms, treatment, or recovery, but if the young person had questions, I attempted to answer them honestly and succinctly. I did not dwell on the topic of my own history, but acknowledged it, and then circled back to details regarding the current study.

Some may question my decision to disclose, or even say that it was unethical or biased. I am well aware that sharing something personal about myself is not a "typical" or "conventional" approach to research – even in qualitative work. However, I would never ask someone to say, do, or disclose something that I, myself, would not say, do, or disclose. I respect the participants in this – and all – studies, and I am humbled by them. If I ask that they share personal and sometimes painful memories from their own lives with me, I think it only fair that I do the same. I also believe, as Virginia Woolf once

wrote (1947), "If you do not tell the truth about yourself, you cannot tell it about other people." By telling the truth about my self, both to the study participants, as well as to readers, I hope to strengthen my own credibility and, in turn, make my interpretations of the participants' experiences more trustworthy, as well.

**Overview of Methodology and why Mixed Methods?**

Mixed methods involves mixing or combining quantitative and qualitative research techniques, methods, approaches, concepts or language into a single study, or across several linked studies (Johnson & Onwuegbuzie, 2004). It involves "the intentional collection of *both* quantitative and qualitative data and the combination of the strengths of each to answer research questions" (Creswell et al., 2011, p. 5).

Qualitative research approaches often emphasize nuance, detail, complexity, context, individual difference, and the inclusion of study participants' perspectives, perceptions, and voices; such approaches are fertile ground for hypothesis *generation*. Quantitative approaches, in contrast, allow for standardization, comparison within and across groups, findings that are generalizable to entire populations, and hypothesis *testing*. Teddlie and Tashakorri (2009) remind us "in the real world of research, however, continua of philosophical orientations, rather than dichotomous distinctions, more accurately represent the positions of most investigators" (2009, p. 94). They conceive of qualitative and quantitative approaches as different ends on a continuum as opposed to being entirely discrete.

Most social scientists now concede that human development is not nature *versus* nurture, but – like most complex processes – is a messy combination of both. In the same way, I believe that research does not have to be "either, or" but can embody the strengths

of various paradigms and approaches. In the same way that one of my goals for this study is to move beyond a biomedical *versus* social approach and toward more holistic conceptions of mental illness, disability, and recovery, I chose to move beyond strict division in my choice of methods, as well. I was and remain equally interested in exploring the experience of a particular phenomenon for a certain group of people, as well as potentially transferring and adapting these findings to a larger population. Mixed methods makes this possible, bridging diverse philosophical positions and seemingly opposing worldviews (e.g. post-positivist and constructivist) to ultimately promote a "pragmatic" or "what works" perspective on knowledge creation. In selecting mixed methods, researchers give primacy to the importance of the chosen research problem and question(s), and openly value both objective and subjective knowledge (Morgan, 2007). They (we) choose to combine particular methods or procedures with the intention of answering research questions in the most comprehensive and effective way(s).

Although the methods employed in this study will be explained in detail in Chapter Four, *Research Methodology and Design*, below is a brief overview. In this study I employ a slight adaptation of what Creswell (2014) calls an "exploratory sequential mixed methods design." Typically, this type of design entails the collection and analysis of qualitative data first, which then informs the subsequent collection and analysis of quantitative data, and then culminates in the merging of the two databases to garner a more comprehensive understanding of a particular phenomenon. I followed this general procedure, using initial qualitative findings to inform the creation of a survey. However, I expanded upon the original research model, making this study longitudinal and adding a

second wave of qualitative data collection a year after the first wave. (Please see Figures 1.2 and 1.3 on page 17.)

First, I employed purposeful sampling (Patton, 2002, 2015) to ensure the inclusion of participants who varied on a wide range of characteristics (e.g., gender, age, race and ethnicity, psychiatric disability and treatment history, and type of college or university currently attending).

I collected qualitative data in the form of semi-structured interviews from 26 interview participants, and then analyzed these data through a process informed by grounded theory (Glaser & Strauss, 1967). This analysis led to the emergence of three "core codes" that form a theory of "education for recovery" grounded in the data.

Next, I used emerging themes from the analysis of that first wave of data collection to inform the design of a survey. The survey was conceived as a way to further investigate college transition experiences with a larger sample, and items addressed respondents' diagnoses and treatment histories; high school experiences; choices surrounding mental health disclosures in educational contexts; college planning and application activities; and use of academic accommodations in higher education. The survey also included validated measures of college "integration" (IIS, French & Oakes, 2004) and respondents' perceptions of their own "recovery" (RAS, Corrigan et al., 1999; Corrigan et al., 2004). These measures were included to test investigate potential associations among levels of mental health disclosure in educational contexts, social and academic integration, and self-perceived recovery.

After implementing the survey to 22 of the original qualitative study arm participants, as well as to 56 other anonymous survey respondents (total n =78), I then

did follow-up interviews with the 22 continuing interview participants to further explore their college transitions over time.

Ultimately, I merged the qualitative themes with select and related quantitative findings to paint a nuanced picture of the experience of college preparation, transition, and ongoing recovery. This analysis led to the creation of recommendations to inform policy and practice at both the individual (student) and institutional (college) level to better support integrated learning and recovery for students with psychiatric disabilities.

**Figure 1.2** Typical steps in an Exploratory Mixed Methods Sequential research design

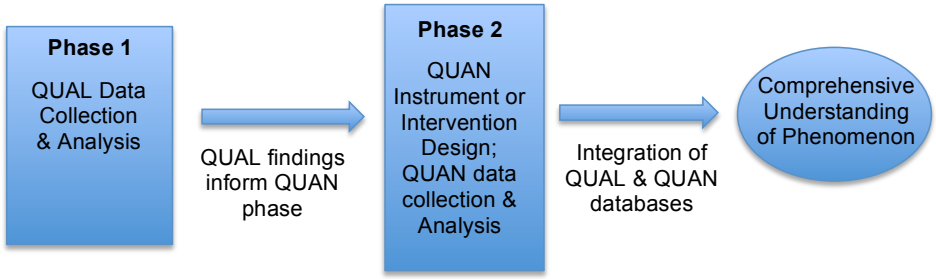
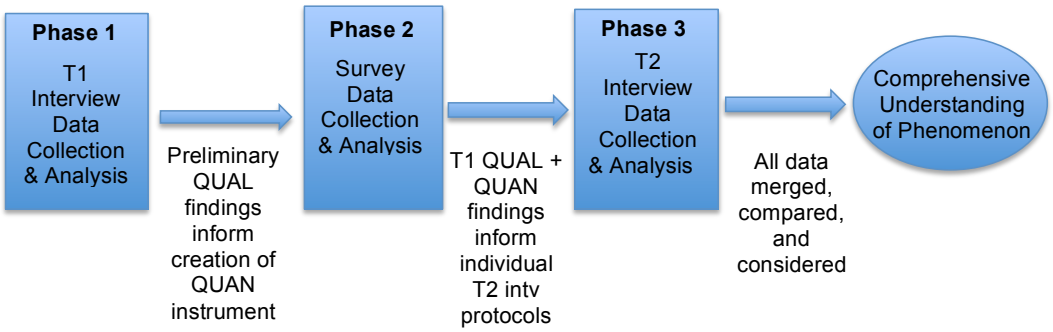



**Figure 1.3** Adapted Design: Exploratory Sequential Longitudinal Mixed Methods Design



## Definition of Terms and Related Abbreviations

**Accommodations**

To ensure that their campus programs are fully accessible to students with all types of disabilities, colleges and universities are required by the Americans with Disability Act (see ADA, below) to provide "reasonable accommodations." The legislation requires that colleges and universities make reasonable modifications to their practices, policies and procedures in order to ensure equal access to higher education for students with disabilities. In addition, accommodations are individualized for each student depending on his or her needs. Examples of accommodations include, but are not limited to: extra time on exams; note-takers for lectures; preferential classroom seating; or a reduced course load. (Disabilities Rights California, 2013)

**Americans with Disabilities Act (ADA)**

The ADA is a wide-ranging civil rights law passed in 1990 that prohibits discrimination on the basis of disability in employment, State and local government, public institutions, commercial facilities, transportation, and telecommunications.

**Americans with Disabilities Act Title II: State and Local Government Activities**

Title II of the ADA requires that State and local governments give people with disabilities an equal opportunity to benefit from all of their programs, services, and activities, including *public education*, employment, transportation, recreation, health care, social services, courts, voting, and town meetings. (U.S. Dept of Justice, 2009)

**Campus-based Counseling and Psychological Services (CAPS)**

This term is used in this dissertation as a catch-call to reference the various types of professional counseling, mental health, and psychological services and supports offered on U.S. campuses. Although each campus' services are unique and there is wide variation regarding offerings, quality, and availability of services across colleges, there are come general commonalities. If a college or university has a counseling center, the most common services are: confidential short-term individual counseling, consultation, workshops, couples counseling, therapy groups, student-life groups, sexual assault prevention, alcohol or other drug prevention, psychiatric consultation and/or medication management, and referrals for longer-term therapy to students as part of their tuition. (Reetz, Krylowicz, & Mistler, 2014)

**College integration**

For the purposes of this dissertation, this term is operationally defined as the process of becoming integrated into the academic and social systems of a college, and of coming to share peer and faculty attitudes and beliefs. (Tinto, 1975; Pascarella & Terenzini, 1991)

**Concealable Stigmatized Identity**

Any one of a number of personal characteristics or experiences that is not readily observable by others, and is often considered embarrassing, shameful, or cause for discrimination. Examples include: sexual orientation minority status; having a psychiatric disability; being HIV sero-positive; having had an abortion. (Chaudoir & Fisher, 2010)

**Diagnostic and Statistical Manual of Mental Disorders – 5th edition (DSM-5)**

The 2013 update to the American Psychiatric Association's (APA) classification and diagnostic tool. This publications serves as a universal authority for psychiatric diagnosis. (American Psychiatric Association, 2013)

**Disability**

An individual with a disability, according to U.S. federal law (ADA; Section 504 of the Rehabilitation Act) is any person who "(a) has a physical or mental impairment that substantially limits one or more of such person's major life activities, (b) has a record of such an impairment, or (c) is regarded as having such an impairment." Here, major life activities "include caring for one's self, walking, seeing, hearing, speaking, breathing, working, performing manual tasks, and learning." (U.S. Dept of Justice, 2009)

**Disability Studies (DS)**

DS is an academic discipline that examines the meaning, nature, and consequences of disability as a social construct. The international Society for Disability Studies "promotes the study of disability in social, cultural, and political contexts." In its mission statement, the society recognizes "that disability is a key aspect of human experience, and that the study of disability has important political, social, and economic implications for society as a whole, including both disabled and nondisabled people...[We] seek to augment understanding of disability in all cultures and historical periods, to promote greater awareness of the experiences of disabled people, and to advocate for social change." (Retrieved from www.disstudies/org/about/mission-and-history)

**Disability Studies in Education (DSE)**

Disability Studies in Education is a scholarly movement that emerged from DS to promote the understanding of disability as a social construct, and to explore and interrogate medical, scientific, and psychological models of disability as they relate to education. (See www.hunter.cuny.edu/conferences/dse-12/mission-and-tenets-of-dse)

**Disclosure**

Within the "Disclosure Processes Model" framework (DPM), a situation in which a discloser verbally reveals information to a confidant about the discloser's concealable stigmatized identity - information that was not previously known by the confidant. (Chaudoir & Fisher, 2010)

**Emerging Adulthood (EA)**

The period of development encompassing the late teens through the early to mid twenties, and distinct from both "adolescence" and "early adulthood." Usually considered to be ages 18-25. (Arnett, 2004).

**Emotional Disturbance (ED)**

This term is used in the nation's special education law, the Individuals with Disabilities Education Act (IDEA), and is defined as follows:

"…a condition exhibiting one or more of the following characteristics over a long period of time and to a marked degree that adversely affects a child's educational performance:

- An inability to learn that cannot be explained by intellectual, sensory, or health factors.

- An inability to build or maintain satisfactory interpersonal relationships with peers and teachers.
- Inappropriate types of behavior or feelings under normal circumstances.
- A general pervasive mood of unhappiness or depression.
- A tendency to develop physical symptoms or fears associated with personal or school problems."

Children who meet criteria for ED in the U.S. are legally protected from discrimination in educational settings under the IDEA and are entitled to a free and appropriate public education. (Individuals With Disabilities Education Act, 20 U.S.C. § 1400 (2004).

**Invisible Disability**

Similar to "concealable stigmatized identity," above, an invisible disability is one that is not easily observed by others, unlike many physical or sensory disabilities. Examples of invisible disabilities include learning and developmental disabilities such as dyslexia and ADHD; more mild forms of autism; and most psychiatric disabilities.

**Individuals with Disability Education Act (IDEA)**

"The Individuals with Disabilities Education Act (IDEA) (formerly called the Education for all Handicapped Children Act of 1975) requires public schools to make available to all eligible children with disabilities a free and appropriate public education in the least restrictive environment possible. IDEA also requires public school systems to develop appropriate Individualized Education Programs (IEPs) for each child. The specific special education and related services outlined

in each IEP reflect the individualized needs of each student." (U.S. Department of Justice, 2009)

**Individual Education Program (IEP)**

"Each public school child who receives special education and related services must have an Individualized Education Program (IEP). Each IEP must be designed for one student and must be a truly *individualized* document. The IEP creates an opportunity for teachers, parents, school administrators, related services personnel, and students (when appropriate) to work together to improve educational results for children with disabilities. The IEP is the cornerstone of a quality education for each child with a disability." (Retrieved from: http://www2.ed.gov/parents/needs/speced/iepguide/index.html)

**Mental Health Literacy**

Mental health literacy consists of knowledge and beliefs about mental disorders that can aid in their recognition, management or prevention (Jorm, Korten, & Jacomb, 1997).

**Mental illness (MI)**

The term "mental illness" describes a broad range of mental and emotional conditions including, but not limited to: major depression, anxiety disorders, and psychotic disorders such as schizophrenia. (Boston University Center for Psychiatric Rehabilitation). Mental illnesses disrupt a person's thinking, feeling, mood, ability to relate to others and daily functioning. All of these disorders have episodic, recurrent, or persistent features; however, they vary in terms of severity and disabling effects. (National Institute of Mental Health)

*Note that this is the term employed in the survey for this dissertation, with the caveat made to respondents that it is an imperfect term, and that many people prefer other terms, such as "mental health condition" or "psychiatric disability," or, simply, not label at all.

**Mental health help-seeking**

Behaviors related to seeking help for oneself or someone else for (1) the promotion of mental health and wellness or (2) the treatment of mental illness. (Examples might include making a call to a crisis hotline on behalf of a roommate who may be suicidal; joining a family support group at an organization like the National Alliance on Mental Illness; or making an appointment for yourself with a counselor.)

**Mood Disorder**

A category of psychological disorder that includes major depressive disorder, dysthymia, and bipolar disorder I and II). Twelve-month prevalence rate for any mood disorder is 9.5%. (Kessler et al., 2005b)

**Psychiatric Disability (PD)**

The DSM-5 defines a psychiatric disability as a clinically diagnosed behavioral or psychological syndrome or pattern that occurs in an individual and is associated with present distress (APA, 2013). The same term is used in the Disability and Psychiatric Rehabilitation literature to describe a mental illness that significantly interferes with a person's performance of major life activities - such as learning, working and communicating (Boston University Center for Psychiatric Rehabilitation). However, the term (much like "mental illness," above,) is one

that certain people embrace while others criticize as overly medicalized or simply not reflective of their experience. The term is used in legislation (such as the ADA, mentioned above), but is not necessarily the term of choice for many people who live with mental health challenges – including the majority of participants in this study. Despite its limitations, however, I employ this term throughout this dissertation because it is the verbiage most aligned with disability legislation and Student Disability Services on college campuses.

**Section 504 of the Rehabilitation Act of 1973**

Section 504 of the Rehabilitation Act of 1973, a civil rights law, prohibits discrimination on the basis of disabling conditions by programs and activities receiving or benefiting from federal financial assistance.

**Social Anxiety**

"People with social anxiety disorder (sometimes called "social phobia") have a marked fear of social or performance situations in which they expect to feel embarrassed, judged, rejected, or fearful of offending others. Social anxiety disorder symptoms include: feeling highly anxious about being with other people and having a hard time talking to them; feeling very self-conscious in front of other people and worried about feeling humiliated, embarrassed, or rejected, or fearful of offending others; being very afraid that other people will judge them; worrying for days or weeks before an event where other people will be; staying away from places where there are other people; having a hard time making friends and keeping friends; blushing, sweating, or trembling around other people; feeling nauseous or sick to your stomach when other people are around." (NIMH, 2016).

Text retrieved from: http://www.nimh.nih.gov/health/topics/anxiety-disorders/index.shtml

**Stigma**

The prejudice, avoidance, rejection and discrimination directed at people believed to have an illness, disorder or other trait perceived to be undesirable. (Link & Phelan, 2001).

**Student Disability Services (SDS)**

This term is used throughout this dissertation to signify both the office/organization on individual college campuses that is intended to provide services and supports to students with self-identified disabilities, as well as the specific services offered by these offices and their staffs. I recognize that there is great variety among colleges and universities regarding their actual offerings for students with disabilities. That said, this term is not intended to imply uniformity across institutions; rather, it is meant as a short-hand to represent all offices and their related services, allowing for the reality that colleges employ different names for these offices (e.g. Student Disability Services, Disability Resources and Services, Student Disability Resources, etc.)

# CHAPTER 2

# CONCEPTUAL FRAMEWORK

## Chapter Overview

In this chapter, I describe the conceptual framework guiding this study. It is comprised of three interacting elements: (1) my own experiential knowledge, (2) a specific worldview that is the foundation for my conception of knowledge creation, "truth," and the critical role of relationships in ethical and credible research, and (3) several existing theories that buttress my approach to working with and for youth and young adults with psychiatric disabilities. Before exploring these concepts further, I take a moment to interrogate the concept(s) behind a "conceptual framework."

## Operational Definition for Conceptual Framework

There are many definitions for a conceptual framework (Maxwell, 2005; Miles & Huberman, 1994; Ravitch & Riggan, 2012). For the purposes of this dissertation, I rely primarily on Maxwell (2005) and Ravitch and Riggan's (2012) operational definitions for the term, below.

> A conceptual framework is a grounded argument about why the topic of a study matters to its various and often intersecting fields, why the methodological approach used to explore the topic is valid, and the ways in which the research design is appropriate and the methods are rigorous. (Ravitch & Riggan, 2012, pp 39-44).

> The function of this theory is to inform the rest of your design – to help you assess and refine your goals, develop realistic and relevant research questions, select appropriate methods, and identify potential validity threats to your conclusions. It also helps you *justify* your research. (Maxwell, 2005, pp. 33-34).

I would add to these complementary working definitions that my own conceptual framework also includes what I find interesting in the world (read: worthy of formal

study), what questions I ask about these phenomena of interest, and how I go about trying to answer them. The conceptual framework, then, informs every decision related to my study design and is, by definition, constructed, highly subjective, and unique to this particular study.

I conceive of myself as a "well-informed" traveller (Witzel & Reiter, 2012), sharing certain knowledge and lived experiences with the participants in this study, while differing from them in many ways, as well. My conceptual framework acts as a sort of travel guide; its elements are signposts to remind me of the way as I go on this journey. Some signs remind me of the commonalities I share with study participants, while others highlight what sets us apart; some signs reflect my pragmatic approach to research, while others point to my constructivist and interpretivist bent; and some signs remind me of useful existing theories that form well-trod paths and make my journey more feasible, organized, and connected to other travellers.

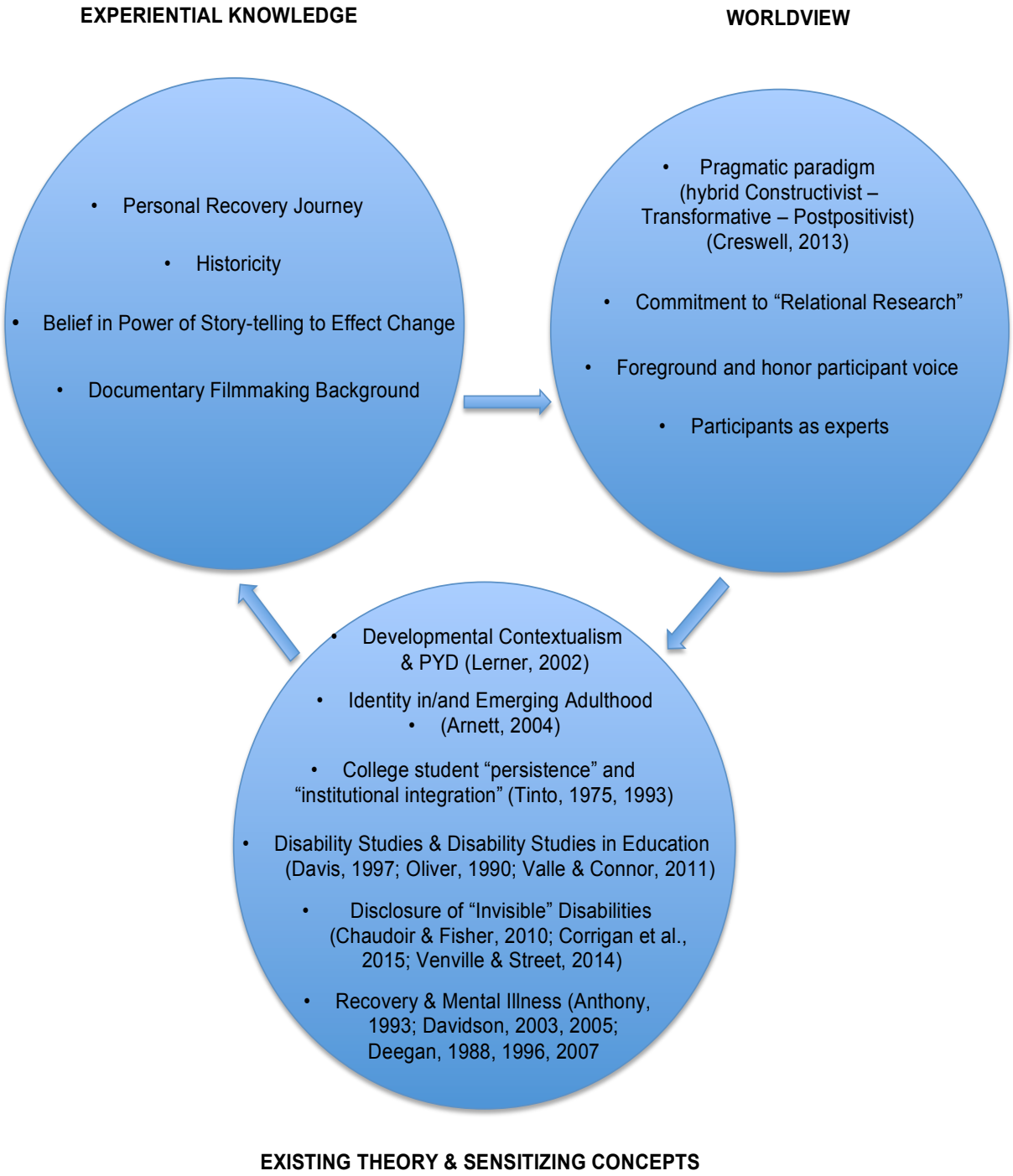
On the following page is a figure representing the conceptual framework for this dissertation (Figure 2.1). It is comprised of three over-lapping and interacting components: my own experiential knowledge, my worldview (or how I conceive of and understand knowledge creation and "truth"), and various relevant existing theories and sensitizing concepts.

**Experiential Knowledge**

My personal history is – as is everyone's - undeniably biased; it also, however, unique and valuable. I believe that my experiences inform what I find important and ripe for research, as well as the specific questions that I ask and the choices and methods I employ to go about exploring them. At the risk of sounding egocentric, I believe that this

particular study, with these particular research questions, and some particularly wonderful study participants, could not have been conducted by someone else. This is not good or bad – it simply is, in the same way that other qualitative and mixed methods studies could not have been conducted by anyone but *their* authors. That said, I endeavor to be transparent about the assumptions I have brought to this work and how I understand the world and my small place within it. Without such transparency, how can readers assess the trustworthiness of my findings?

**Figure 2.1** Conceptual Framework for Dissertation




*Note: "PYD" above is abbreviation for "Positive Youth Development"

**Personal recovery journey.** Early in my freshman year of high school, I experienced growing depression and an increasing discomfort with my body. By the Spring of that year, my sadness and unease had become anorexia nervosa and major depressive disorder. I withdrew socially from friends, felt increasing hopelessness, exercised compulsively and excessively, and subsisted on a severely restricted diet. Within a matter of eight weeks, I was very thin and pale, and achingly depressed. After a few months more, I was gaunt, hardly eating at all, and contemplating suicide. Fortunately for me, my parents forced me into treatment early and against my will; if they hadn't acted so quickly I doubt that I would be alive today.

After a year of thrice-weekly individual sessions with a pediatric psychiatrist who specialized in eating disorders, coupled with twice-weekly group-therapy with other teenage girls, and regular meetings with a registered dietician, I began the road to eating disorder recovery, and fortunately have never had a relapse. One thing that all of the treatment did not prepare me for, however, was what to say to my friends and teachers at school about what was happening me – and how to maintain a positive academic and social existence during and after my treatment.

This was in 1987, and the staff at my private high school had no connections with community mental health agencies (or *any* community agencies, for that matter), and certainly no direct communication with my doctors. My mother became my personal caseworker out of desperation and necessity, and she did her best to keep the medical team, the school counselor, and my dean abreast of my progress. She fumbled her way through, with no built-in supports to help her navigate the maze, yet she somehow managed to do a stellar job. However, one key element that was not considered along the

way was what *I* should do and say to the people at school – and what *they* could do to support me through this process.

Fortunately, I did not require a lengthy hospitalization, but my day treatment appointments were frequent, cut into school hours, and went on for many months. Confused and embarrassed, I didn't know how to account for my numerous school absences, or how I would be perceived if I told the truth. I ended up saying to most people that I had "a series of oral surgeries, " and to this day, I don't know how I decided on such a specific and ridiculous excuse. I also realize now that the fact that I had lost so much weight, was not allowed to participate in gym class, and refused to enter the cafeteria or eat in public had probably already given me away.

I did have three close friends who knew the whole truth about my illness and my absences because I decided to tell each of them separately about elements of my experience. They each were warm and wonderful recipients of my disclosure, and without their support I would not have survived school and simultaneous outpatient treatment. That said, for many years I have contemplated how serious mental health conditions can influence a young person's academic identity and experiences in school, above and beyond the physical, cognitive, and emotional challenges of the disorder. Even now, I am not certain what compelled me to tell my three best friends about my mental illness and recovery, and I also still do not know what might have been a better choice than "oral surgery" to explain to everyone *else* at school where I had been, and why.

**Historicity.** I am a product of my individual experiences, but also of my culture and era. In the same way, this research is a product of the historical moment in which it has taken place. The design of this study's conceptual framework is deeply influenced by

the historical moment in which the study took place. This research was conducted during a time of heightened national attention to mental health and mental illness - particularly related to youth and young adults. At no other time in history have we engaged in this type of public conversation.

***The contemporary moment.*** In many ways, this study is book-ended by the school shootings at Sandy Hook Elementary in 2012[1] at its outset, and by the most recent undergraduate suicide on my own home campus at its conclusion[2]. Unmet mental health needs among young adults continue to be significant, and they sometimes result in tragedy. Though I take issue with the media's tendency to sensationalize pathology – particularly when assumed to be linked to violence – I acknowledge that we live in a unique historical moment, and that numerous recent school shootings and campus suicides[3] demand a refocusing of attention toward the critical task of transformative change.

As someone with my own lived experience of mental illness, I am deeply committed to sharing complex stories of recovery. When I was in high school and college, the national climate and public dialogue surrounding youth mental health was distinctively different from what young people experience today. Back then, there were

[1] A lone gunman and young adult, Adam Lanza, killed 6 educators and 20 first-graders at Sandy Hook Elementary School in Newtown, CT on Dec. 14, 2012.

[2] There have been ten student suicides at the University of Pennsylvania between Feb, 2013 and April 2016. The most recent occurred on April 11, 2016. *The Daily Pennsylvanian* covered the story here: http://www.thedp.com/article/2016/04/student-suicide-prompts-criticisms-of-administration

[3] There have been 187 school shootings in the US since 2013. See "Everytown For Gun Safety" statistics here: http://everytownresearch.org/school-shootings/

no television commercials for anti-depressant medications; student clubs such as Active Minds[4] to promote mental health on college campuses had not yet emerged; national efforts to prevent campus suicides had not yet been initiated[5]; and "acting bipolar" was not considered an adolescent badge of honor. In addition, we as a country had not yet weathered the campus shootings at Columbine High School, Virginia Tech, and Sandy Hook Elementary. Our focus had not yet shifted to youth and mental illness.

Today, our culture is steeped in conversations related to youth mental health, yet the national dialogue seems limited to connections among unmet mental health needs and devastating tragedy. I believe that we have neglected to shed light on other types of equally important stories - stories of resilience, thriving, and young people surpassing expectations. It is with this in mind that I conceived of the present study.

***My own coming of age (the 1990s).*** When I was in college in the 1990s, it was the National Institute of Mental Health's "decade of the brain"[6]. Advances in

[4]Founded in 2004 at the University of Pennsylvania by then-undergraduate student Alison Malmon, Active Minds is a non-profit organization using student voice "to change the conversation about mental health on college campuses." The organization develops and supports chapters of student-run mental health awareness, education, and advocacy groups on campuses. (http://scholars.activeminds.org/about-emerging-scholars/about-active-minds)

[5]For one example of contemporary and nation-wide work to prevent campus suicide, see The Jed Foundation: https://www.jedfoundation.org/

[6] "From 1990 to the end of 1999, the Library of Congress and the National Institute of Mental Health of the National Institutes of Health sponsored a unique interagency initiative to advance the goals set forth in a proclamation by President George Bush designating the 1990s as the Decade of the Brain: 'to enhance public awareness of the benefits to be derived from brain research through 'appropriate programs, ceremonies, and activities.' (Library of Congress website: www.loc.gov/loc/brain/)

identification and treatment of mental illness - including new brain imaging techniques and psychotropic medications – helped to make college a possibility for many young adults who a decade prior might not have graduated from high school (Sharpe, Bruininks, Blacklock, Benson, & Johnson, 2004). The disability rights movement had been well underway for approximately fifteen years (Winter, 2003), and research and commentary regarding racial, ethnic, and cultural "diversity" in schools and colleges was becoming common (Afolayan, 1994; Hurtado, Milem, Clayton- Pedersen & Allen, 1998). In addition, work exploring "full inclusion" for students with disabilities was prevalent in both scholarly literature and the national media (Chira, 1993; Marriot, 1990; Zigmond & Baker, 1996). The 1975 Education for All Handicapped Children Act was reauthorized in 1990 and given the new name "Individuals with Disabilities Education Act" (IDEA), setting the stage for inclusive public education and guaranteeing access to learning for every child.

I came of age when *Prozac Nation* (Wurtzel, 1994) was a *New York Times* bestseller. It was penned by its author when she was only 26, and its message reverberated across the country. As a college Senior myself, I remember hearing Elizabeth Wurtzel speak about her journey through depression and her experiences with psychopharmacology when she visited our campus on a book tour. I appreciated her book and her talk, and it resonated with my own experience; but, strangely, I felt no inkling to tell any of my friends in college about my mental health history. My own story of "madness," medication, and recovery seemed distant, surreal, and very much in the past. I had been healthy and free of eating disorder and depressive symptoms for several years and I felt no need to unearth them.

After college, I went to film school and embarked on my first career as a documentary filmmaker. I discovered the genre of the "essay film" and was inspired by the power of first-person narrative and experimental film techniques to share intimate experiences. When I was 25 (still an emerging adult myself), I attempted to use film to link my personal experience with mental illness in high school to broader themes of identity and recovery. I was finally ready to "come out" myself. The resulting film, *Slender Existence*, was to my knowledge the first documentary about recovery from anorexia that was directed, edited, and narrated by someone who had actually had the disorder. I told (disclosed) the story of my recovery in screenings in friends' living rooms, in campus theaters and, later on public television. Audiences seemed surprised at my candor and I was lauded for my "bravery" and called "a feminist filmmaker." I felt a lightness and freedom that I hadn't felt before. In a way, making and sharing the film was a type of exorcism - a way to tell a story and then be done with it. Except that this story wasn't over. And I was naïve to have believed that the telling would lock my experience in the past like a tree in a petrified forest.

As I was screening *Slender Existence* around the country, my depression came back in full force. What I thought had come and gone – something solely in the past – had returned with ferocity. The experience necessitated a reframing of how I understood recovery, as well as a new humility about the unexpected nature of growth and development. It also forced me to acknowledge that recovery is hard work, and that managing one's mental health while going about the business of becoming an adult takes time, intention, and lots of trial and error.

Fast forward ten years (to when I entered graduate school for education and psychology) and a seeming cottage industry of "memoirs of madness" had erupted in the popular press with parents, siblings, and people in recovery themselves sharing their stories in print and on screen. A new and needed era of honesty and openness about the prevalence of mental illness, evolving treatments, and personal experiences of recovery had emerged. Though the courage and candor of these authors should be lauded, there are two emerging themes in these works that are conspicuous due to their absence: (1) there are very few descriptions of youth and young adults' experiences of mental illness and recovery *while* they are still youth and young adults (as opposed to filtered through the lens of adult recollection, as I had done in my film), and (2) the few times that education or experiences in school are mentioned are to recount negative events such as doing poorly academically, having a first psychotic break in college, or leaving school altogether, unable to return.

In reviewing many of these memoirs, I became interested in the possible counter-narrative of young people doing *well* in school, not because they "overcome" mental illness or disability, but because they live with and through it; and certainly not because their schools or colleges are particularly helpful during this process, but often in spite of it. I was developing what I now recognize as a strengths-based approach to conceiving of education and continued development for students with psychiatric disabilities, conceptualizing their educational pathways as not *apart* from their experiences of mental illness and recovery, but as an integral part *of* them. This interest is the root of my dissertation study, and, I hope, much future work, as well.

**The power of storytelling.** My professional background in documentary filmmaking is married with a strong belief in the transformative power of storytelling to catalyze social change. Whether in the form of a memoir, journalistic article, radio commentary, campaign speech, or documentary film, an authentic personal narrative can shine light on dark places, translate silence into speech, energize, educate, and even spark social justice movements. This conviction in the power of storytelling was the impetus for my filmmaking work, and it remains at the root of my commitment to rigorous qualitative research. As the late, great, Maya Angelou has said, "there is no greater agony than bearing an untold story inside you." And creating the space, place, and relationships that bring people's stories to light for the common good is part of what I hope to do as a researcher.

## Worldview(s)

A worldview, or paradigm, is "a general philosophical orientation about the world and the nature of research that a researcher brings to a study" (Creswell, 2014, p. 6). Put another way, one's worldview, whether made explicit or not, is a basic set of beliefs about knowledge, knowledge creation, and "truth" that guides every element in one's approach to inquiry. The basic assumptions of any given paradigm (e.g. positivist, postpositivist, constructivist, interpretive, critical, etc.) involve the following dimensions: "ontology (the nature of reality), epistemology (the relationship between the inquirer and the known), and methodologies (the methods of gaining knowledge of the world)" (Heppner et al., 2008, p. 7). Here I share my philosophical assumptions and approach to research in order to justify my chosen methodology.

**A Pragmatic (Constructivist – Transformative – Postpositivist) paradigm.** I feel most aligned with what Creswell calls the pragmatic paradigm (2014). He writes:

> Pragmatism as a worldview arises out of actions, situations, and consequences rather than antecedent conditions (as in postpositivism). There is a concern with applications – what works – and solutions to problems (Patton, 1990). Instead of focusing on methods, researchers emphasize the research problem and use all approaches available to understand the problem. (p. 11)

I, too, am primarily concerned with "what works" to answer certain research questions, and I am open to multiple methods and various worldviews. Like other mixed methods researchers, I draw from both qualitative and quantitative philosophies and worldviews, and there are three specific worldviews that I turn to time and again. The following have informed the design of this study, and collectively are the foundation for my *pragmatic* approach: constructivism, the transformative paradigm, and postpositivism.

First, regarding the qualitative arm of this study, I identify with social constructivists who propose that there are multiple realities and that meanings are complex, varied, and "constructed" through interactions with others and the world (Creswell, 2014). In addition, I agree that the goal of qualitative research "is to rely as much as possible on participants' views of the situation being studied" (Creswell, 2014, p. 8) and that my job as a researcher is to co-construct knowledge *with* research participants while continuously acknowledging that they are the experts regarding their own lives. In addition, I recognize that my own background and experience shape my interpretations of study participants' recollections, stories, and the meaning that they (and I) make of their lives. My interpretations of interviews, for example, are filtered through my personal, cultural, and historical experiences (Creswell, 2014, p. 8). I acknowledge, at

least in the qualitative arm of this study, that "what can be known is inextricably intertwined with the interaction between a particular investigator [in this case, me] and a particular object or group [the participants in this study]" (Guba & Lincoln, 1994, p. 110).

In addition to abiding by a constructivist worldview in the design of the qualitative elements of this study, I also adhere to the (complementary) transformative paradigm (also known as "critical theory"). This approach was developed in the 1980s and 1990s as a reaction to postpositivist assumptions and theories that were perceived as not applicable to or inclusive of marginalized populations or social justice issues. The transformative paradigm is generally concerned with pushing against political power, combatting institutional inequity and discrimination, and "transforming" the status quo to confront oppression and improve lives. Although aligned with constructivism in many ways, it moves beyond it by advancing explicit agendas for action and reform (Creswell, 2014, p. 9). Just as I see my (constructivist) role as a facilitator of knowledge co-construction, I see my (critical researcher) role as an advocate and "transformative intellectual" (Lincoln, Lynham, and Guba, 2011). Constructing new knowledge in collaboration with study participants is the goal, as is putting new knowledge into action. As Auerbach and Silverstein propose (2003, p. 125), I intend to not just *describe* the world, but to *change* it (italics in original).

However, despite my strong allegiance to the constructivist and transformative worldviews described here, I am not bound by them. I also see the value of measuring, quantifying, trying to generalize, investigating causal relationships, and benefiting from existing theories while working to create new ones. I use methods allied with

postpositivism to the degree that they allow for the testing of hypotheses, or, for example, the statistical analysis of close-ended survey responses. Even here, however, I subscribe to the idea that all research, in some way, is filtered through the subjective lens of the researcher. For example, in this study I designed the survey, composed the individual items, and advertised online to recruit respondents. In this way, even knowledge resulting from the quantitative strand of this study is "constructed" because it results from the subjective decisions that I made regarding data collection.

**A "relational" approach to social science research.** Because I feel strongly about foregrounding the role of study participants in the co-construction of knowledge, I take a moment here to make explicit my deep respect for and appreciation of the participants in this study. They are the experts regarding their own lived experiences, and they are consistently constructing their own identities and understanding of their place in the world in interactions with peers, families, neighbors, co-workers, and others in their various "ecological systems" (Bronfenbrenner, 1998). In our conversations and interviews, the study participants and I came together and forged relationships – some short-term and others ongoing - and I believe that these continue to affect us. Even after completing all of the interviews with participants (the details of which are described in Chapter Four, *Research Methodology and Design*), I continue to see myself "in relation with them and the experiences that we have co-constructed" (Clandinin & Murphy, 2009, p. 600). I feel ethically and relationally committed to representing their experiences in as accurate and authentic a way as possible. As Clandinin and Murphy (2009) write,

> In composing our research texts, we speak turned in two directions. First, and most important, we speak to our participants and ourselves to fulfill the relational responsibilities of representing our co-constructed experiences. *The priority in*

> *composing research texts is not, first and foremost, to tell a good story; the priority is to compose research texts in relation with the lives of our participants and ourselves*. (p. 600, italics added for emphasis)

I would add, however, that I do not believe that "telling a good story" and "composing research texts in relation with participants" are mutually exclusive goals. It is with this in mind that I set about representing study participants' experiences respectfully, authentically *and* aesthetically in the form of a valid text that they, the public, and other scholars might appreciate in diverse ways.

**Existing Theory and Sensitizing Concepts**

In addition to my experiential knowledge and worldview, the third component of the conceptual framework for this study is made up of several existing theories and constructs that I utilize as "sensitizing concepts" (Blumer, 1969). These are bodies of knowledge that act as "points of departure" (Charmaz, 2006, p. 17) and an overall orienting lens for the study (Bowen, 2006). The sensitizing concepts I employ both inform the study's design and my interpretation of findings, and each emerged from a thorough review of the literature related to my research problem. They are: *Developmental Contextualism* and *Positive Youth Development (PYD)*; *Identity* in *Emerging Adulthood*; conceptions of *"institutional integration"* and *"persistence"* for college students; *Disability Studies* and *Disability Studies in Education*; *recovery* and mental illness; and *disclosure* of *"invisible disabilities."* Before describing each of these, below, I should explain that my use of existing theory and constructs in this dissertation is three-fold.

First, I rely on these bodies of knowledge as integral elements of my conceptual framework. Second, I lean on them when working toward developing a *new* substantive

theory (Glaser & Strauss, 1967, p. 32) in the qualitative strand of the study. I use an inductive process and build up from "grounded" interview data to broader themes, but then combine these emerging themes with four deductive constructs derived from the literature (*Identity* in Emerging Adulthood, *Disclosure* of invisible disabilities, *Institutional Integration* for college students, and the process of *Recovery* for people with psychiatric disabilities). I then use these a priori constructs as cross-cutting themes that, in tandem with the grounded and data-driven themes, inform a model of successful student transitions.

And, third, I utilize measures of *Disclosure, Institutional Integration*, and *Recovery* in the quantitative arm of the study. Survey items related to these variables allow for investigation of relationships among them, and ultimately for testing the hypothesis that higher levels of psychiatric disability disclosure in educational contexts are positively correlated with higher levels of institutional integration and self-perceived recovery.

**Developmental Contextualism and Positive Youth Development.** As a continuation of the above discussion of "relational research" (see p. 39), I turn now to two linked theories made famous by Lerner et al. (2002; 2005; 2013). Developmental contextualism is one of several relational developmental systems theories (Bronfenbrenner & Morris, 1998; Lerner, 2005; Overton & Muller, 2013) positing that the fundamental process in human development across the life span is person←→context interaction. Put another way, it is "dynamic individual-context relations that provide the basis of behavior and developmental change" (Lerner & Castellino, 2002, p. 124). In Contextualism, development is conceived as a relational process involving mutually

influential interactions between the developing individual and the multiple levels of his or her ecology (Lerner, 2005, p. 9). Development is always the product of a bi-directional person-context interaction and individuals are understood as producers of their own development. Just as adolescents and young adults are influenced by their parents, peers, and teachers, young people also influence the many individuals with whom they interact.

In addition to continuous interactions within various contexts over time, the second essential component of contextualism is the concept of "relative plasticity" across the lifespan. Here, individuals are understood to always be capable – to various degrees - of change and growth. And, finally, the match, or "goodness-of-fit" between and among individuals and their environments is also conceived as a primary driver of healthy development and wellbeing.

Contextualism gave rise to the concept of Positive Youth Development (PYD) (Lerner, 2005). Eschewing the deficit model of adolescent development, PYD emerged in the 1990s and early 2000s as an approach to both research and applied work with youth. It takes a strengths-based approach and seeks to nurture the *potential* of youth, rather than focusing on perceived deficits. The model reframes youth as "resources to be developed, and not as problems to be managed" (Lerner, 2005, p. 27) and it situates youth within – never apart from - ecological systems (Bronfenbrenner & Morris, 1998). PYD moves beyond the individual and focuses on *relationships* as the primary unit of analysis. Ultimately, promoting alignment between young people and their environments is seen as a way to promote PYD, and the model seeks to intentionally and effectively shape developmental contexts in order to enhance optimal development.

Although it has historically been focused on adolescents, PYD and its principles can be applied to young and emerging adults, as well. Consciously constructing healthy environments (such as colleges and universities), and relationships (e.g. between faculty and students) in which young adults can practice agency while receiving needed scaffolding and supports can theoretically promote positive development and thriving. In addition, applying the PYD framework to young adults with psychiatric disabilities, in particular, is a transformative approach. It allows for the exploration of "possibility development" (Nakkula & Toshalis, 2008, pp 61-77) and even flourishing (Seligman, 2011) among college students with mental illness, not apart from their "disability" or "disorder," but in relation *to* it; and not apart from the broader campus community, but as a dynamic part *of* it.

**Identity in/and Emerging Adulthood.** For many decades, identity development has been considered a fundamental psychosocial task for youth, as well as a key element in the transition to adulthood (Erikson, 1950, 1968; Marcia, 1966; Lerner, 2005; Schwartz, Zamboanga, Luyckx, Meca, & Ritchie, 2013). Identity formation involves exploring and experimenting with various life roles and possibilities, then gradually moving toward decisions and commitments in various domains. Adolescents, unlike children, have the growing capacity to think abstractly; they can weigh options, imagine potential futures, and consider hypothetical outcomes. This cognitive shift makes it possible, for the first time, to think deeply about "the big questions," such as: "Who am I? "What kind of person do I want to be?" "What do I believe in?" "What kind of career should I pursue?" and "What kind of intimate relationship would be most fulfilling?" (Schwartz et al., 2013, p. 96). The process of answering such questions is both time-

consuming and dynamic. While Erikson (1950; 1968) and Marcia (1966; 1980) focused on adolescence as the time when exploration of identity issues is most prominent and salient, Arnett (2000; 2004) proposed that grappling with "the big questions" extends into a second distinct developmental period: *emerging adulthood.* It is here, he argues, primarily between the ages of 18 and 25, that change, exploration, and experimentation are paramount.

Largely as the result of post WWII technological advances combined with increased college attendance, the late 20th century in the U.S. has cultivated a longer transitional period between school and full-time work for young people, a protracted period of dependence on parents (at least financially) for many, and more time before "settling down" and committing to a particular career or romantic partner. Arnett (2000) argues that the years between 18 and 30 (with a particular focus on 18-25) have become a prolonged stage of "moratorium" (Marcia, 1980) marked by frequent and intense change and exploration for young people in industrialized countries.

> Emerging adulthood is a time of life when many different directions remain possible, when little about the future has been decided for certain, when the scope of independent exploration of life's possibilities is greater for most people than it will be at any other period of the life course. (Arnett, 2000, p. 469)

It is in these years - *the age of possibilities* - that young people have "an unparalleled opportunity to transform their lives" (Arnett, 2004, p. 8) and emerging adults themselves report high levels of optimism and high hopes for flourishing (Arnett, 2004).

The theory of emerging adulthood is useful for this dissertation because its focus on understanding identity development for young people ages 18-25 coincides with the typical age of most U.S. college students (U.S. Dept. of Education, NCES, 2016). More

importantly, however, the theory's focus on identity development and exploration at this stage of life aligns with my interest in the experiences of college students with psychiatric disorders as they explore educational, career, personal, and social interests. Arnett's conception of emerging adulthood as "the age of possibilities" (2004, p. 8) resonates with me. I have seen the type of enthusiasm, optimism, and hope about the future that he describes in many of the emerging adults with whom I have worked as an instructor. In conceiving of this study, I became curious about whether the same sense of optimism and hope about potential futures existed in a sample of emerging adult students with PDs, as well as whether and how educational contexts might promote or quell such optimism and "possibility development" in this population.

**College Student "Persistence" and Institutional Integration.** Research on post-secondary education shows that college completion affords numerous advantages. For example, educational attainment is strongly positively associated with future employment and wage earnings (U.S. Dept. of Labor, 2015). In fact, not only do individuals with a college degree earn more money than peers with only a high school diploma, they are also generally healthier, experience greater job satisfaction, and are more civically engaged (Baum, Ma, & Payea, 2013). Unfortunately, college completion rates differ considerably across demographic groups, and youth and emerging adults with disabilities are far less likely to enter higher education or complete a degree than their peers without disabilities (Collins & Mowbray, 2005; Newman, et al. 2011). In fact, among *all* students with *every type* of disability, youth with emotional and behavioral disorders are the least likely to graduate from high school (Vander Stoep et al., 2003; U.S. Dept. of Education, 2006) and college students with psychiatric disabilities are the least likely to

attain a Bachelor's degree (Collins & Mowbray, 2005; U.S. Dept of Education, 2005). Achieving the highest level of education possible is an essential factor in preparing all young people for independent, healthy, and fulfilling lives, but it is perhaps especially urgent for students with psychiatric disabilities, as they are the subgroup that has historically fared the worst.

Tinto's theory of college student retention and attrition (1975;1993) highlights the dual roles that social integration and academic integration play in student "persistence," or advancing toward and completing a degree. He hypothesizes that experiences at college directly affect a student's commitment to academic goals and to his or her institution more broadly. This commitment, in turn, predicts a student's likelihood of remaining in school and attaining a degree. The theory proposes that students' interactions and experiences with peers and faculty determine the extent to which they feel a part of their institution, with social and academic domains equally important to college retention.

Despite literature from the field of psychiatric rehabilitation linking broad-based "community integration" with recovery for adults with mental illness (Davidson & Roe, 2007; Davidson, Stayner, Nickou, Styron, Rowe, & Chinman, 2001; Salzer, 2006), integration on campus for college students with mental illness is just beginning to be investigated (Salzer, 2012; Jones et al., 2015). Students with psychiatric disabilities face an array of distinct challenges in both academic and social realms (Belch, 2011; Newman et al., 2011; Wagner & Newman, 2012), and full integration and inclusion in a campus community remains a challenge. A deeper understanding of how emerging adults with PDs navigate high school, prepare for, and experience college can inform practices and

policies designed to strengthen college integration. Theoretically, heighted integration will lead to higher rates of retention, degree completion, and – ultimately – to gainful employment, autonomy, and richer, more fulfilling lives.

**Disability Studies (DS) and Disability Studies in Education (DSE).** In the late 1970s, and on the heels of the Civil Rights and Women's Movements, British and American scholars and activists spearheaded a related movement to promote equal rights and inclusion for people living with disabilities. American and British scholars and activists (Abberly, 1987; Asch, 1984; Finkelstein, 1980, 1981; Hahn,1985, 1988; Oliver, 1990; Zola, 1982, 1993) pioneered the *social model* of disability, and this became the foundation around which the burgeoning disability rights movement grew. Unlike its predecessor, the medical model of disability (which conceives of disability as intrinsic to an individual and something to be fixed or "cured"), the social model situates disability not within the individual, but in his or her environment. Although the social model acknowledges that individuals live with specific "impairments" and that supports and services (including medical interventions) are often necessary to manage these impairments, it is the social world that ultimately "disables" an individual through stigma, discrimination, and inequities in access to public institutions and community inclusion. The burden of adaptation and innovation, then, should not be placed on the individual, but should instead lie within broader and "disabling" social contexts.

The Disability Rights movement in the U.S. led to a new academic discipline: Disability Studies. Linton (1998) offers the following description and overview of the field:

> Disability Studies takes for its subject matter not simply the variations that exist in human behavior, appearance, functioning, sensory acuity, and cognitive processing but, more crucially, the meaning we make of those variations. The field explores the critical divisions our society makes in creating the normal versus the pathological, the insider versus the outsider, or the competent citizen versus the ward to the state. It is an interdisciplinary field based on a sociopolitical analysis of disability and informed both by the knowledge base and methodologies used in the traditional liberal arts, and by conceptualizations and approaches developed in areas of the new scholarship. Disability Studies has emerged as a logical basis for examination of the construction and function of 'disability.' (p.2)

Just as Disability Studies (DS) considers disability to be socially constructed and emphasizes interventions in the environment (Strauss & Sales, 2010, p. 80), the related discipline of Disability Studies in Education (DSE) applies these concepts to education. DSE is an outgrowth of DS initiated by special educators critical of how their field historically "positioned disability as a deficit, disorder, dysfunction, abnormality, or aberration" (Connor, Valle, & Hale, 2012, para. 1). They critiqued traditional framings of disability within special education that used "damaging labels and deficit-driven, medicalized conceptualizations of disability that undeniably contradict the views and life experiences of many disabled people" (Connor et al., 2008, p. 445).

DSE is not limited to K-12, and its mission to create and sustain inclusive and accessible schools reaches through higher education, as well. While the numbers of individuals with disabilities participating in higher education are increasing (U.S. Dept of Education, NCES, 2016) major disparities remain. For example, students with disabilities who complete high school are less likely to attend college than their non-disabled peers, they are more likely to attend 2-yr as opposed to 4-yr institutions, and they are less likely to complete their programs of study and attain a degree (National Council on Disability, 2015; Newman et al., 2011).

As Strauss and Sales (2010) explain:

> In order to understand and address these disparities, we must begin to apply the theories and knowledge emerging from Disability Studies to the way that universities frame and respond to disability in academic, research, and service efforts. This is a necessary first step if a university is truly to serve as a catalyst for social change, an engine of economic development, and remain at the vanguard of inquiry and generation of knowledge. (pp 80-81)

DSE is a key sensitizing concept for this dissertation study because it champions a focus on the lived experiences of students with psychiatric disabilities, and also demands interrogation of the ways that colleges and universities influence conceptions of mental illness on campuses, as well as develop and enact policies and practices that tangibly shape students' lives.

**Disclosure of "Invisible Disabilities."** "Invisible disabilities" are those that are not readily apparent to onlookers; examples include debilitating or chronic pain, fatigue, or dizziness; cognitive dysfunctions and brain injuries; serious mental health challenges; learning differences and attention deficits; and hearing and visual impairments. When preparing to transition to college and forging relationships once there, a person with a psychiatric disability is faced with the issue of whether, when, how, and to whom to disclose his or her disability status. Whether or not to keep an invisible disability such as depression concealed is a question particularly salient for young people in academic settings. College students must self-identify as having a disability if they are to access academic accommodations mandated by the federal Americans with Disabilities Act (1990), thus decisions related to disclosing one's mental health history or status can be directly linked to academic success. Unlike in elementary and secondary public education, where schools are tasked with identifying students with disabilities and then providing

"free and appropriate education" (FAPE) (IDEA, 1990; Rehabilitation Act, 1973), in higher education it is the individual student's responsibility to self-identify as having a disability and to register with campus disability services in order to receive academic accommodations (Rickerson & Burgstahler, 2004).

In addition to disclosure being necessary in order to access accommodations on college campuses, there is evidence that disclosure of psychiatric disabilities may decrease self-stigma among adults. "Self stigma" occurs when individuals with psychiatric disabilities internalize negative public beliefs and attitudes about mental illness, which can lead to low self-esteem, shame, anger, hopelessness, and despair. Corrigan et al. (2015, para. 2) write:

> Self-stigma seems to be diminished among people who are 'out' with their mental illness. People who have disclosed their experiences report higher personal empowerment and quality of life (Corrigan et al., 2010). Conversely, people who try to keep issues like mental illness a secret, experience significant negative effects such as diminished self-esteem (Corrigan et al., 2010). As a result, advocates and researchers believe coming out may be a purposeful strategy to erase stigma, replacing it with affirming attitudes like empowerment and recovery (Corrigan et al., 2013).

Despite the potential benefits of disclosing, however, recent research suggests that the majority of college students with serious mental health conditions choose *not* to disclose to any faculty or staff (Venville & Street, 2012; Venville, Street, & Fossey, 2014), they do *not* seek academic accommodations through Student Disability Services (Salzer, Wick, & Rogers 2008), and they generally endorse secrecy regarding their mental health conditions rather than disclosure (Corrigan et al. 2015). Students report that their hesitancy to disclose psychiatric disabilities in college often stems from fear of negative repercussions from faculty, confidentiality concerns, skepticism about the

helpfulness of potential accommodations, and a sense of autonomy that fuels the desire to deal with problems on one's own (Clement et al., 2014; Gruttadaro & Crudo, 2012; Wilson, Rickwood, Bushnell, Caputi, & Thomas, 2011). It is important to note, however, that the limited existing literature related to college students "coming out" with mental health challenges on campus solely addresses disclosures to faculty or staff. There is substantial evidence that adolescents and young adults with mental health challenges are far more likely to turn to same-aged peers to seek help and support than they are to turn to family members, school or university staff, or even mental health professionals (Eisenberg, Downs, Golberstein, & Zivin, 2009; Michelmore, L. & Hindley, P., 2012; Pisani et al., 2012; Rickwood, Deane, Wilson, & Ciarrochi, 2005; Rickwood, Deane, &Wilson, 2007; Wilson et al., 2011). That said, there is a limited understanding of when, why, and how adolescents and emerging adults make decisions and actually carry out such disclosures to friends and peers. This is an area for further study that this dissertation seeks to address.

Chaudoir and Fisher (2010) offer a constructive model for conceptualizing disclosure of a "concealable, stigmatized identity" as a process as opposed to a dichotomous variable (e.g., either "out" or not). Referencing sociologist Irving Goffman's work on stigma and identity (1963), Chaudoir and Fisher (2011) write "single disclosure events are components of a larger, ongoing process of 'stigma management' – coping with the psychological and social consequences of identity" (p. 242). This reminder that sharing something hidden about oneself is a *process* is useful when considering students' experiences negotiating psychiatric disability in educational contexts. Telling is not an "either, or" proposition. Instead, it is a complex and protracted

series of decisions closely linked to identity development, interpersonal relationships, and a young person's insights regarding his or her own recovery needs.

**Recovery and Mental Illness.**

> "…a person with mental illness can recover even though the illness is not 'cured.'" - W. Anthony, 1993, p. 525

> "The goal of the recovery process is not to become normal. The goal is to embrace our human vocation of becoming more deeply, more fully human." – P. Deegan, 1996, p. 30

There is no consensus regarding one particular definition for recovery from a psychiatric disability, but the concept has recurring themes evidenced in multiple studies over time: hope, empowerment, self-determination, goal attainment, and community inclusion are primary. (Corrigan & Phelan, 2004; Davidson, 2003; Davidson, Lawless, & Leary, 2005; Deegan, 1998, 1996; Jacobson & Greenley, 2001; Ochocka, Nelson, & Janzen, 2005). Researchers, mental health professionals and providers, and individuals living with serious mental health conditions have all contributed to the meaning of the term over the past several decades, as well as to understandings of the internal and external circumstances that can promote or hinder recovery (Farkas, 2007, p. 68). To date, much research has been devoted to understanding recovery as an individual-level process (Deegan, 1998; Ridgway, 2001; Smith, 2000; Spaniol & Wewiorski, 2012), with other work exploring and developing system level characteristics to promote recovery (e.g., Anthony, 1993; Jacobson & Cutis, 2000).

The Center for Psychiatric Rehabilitation at Boston University developed the following working definition of recovery from mental illness: "(Recovery is) the deeply personal process of changing one's attitudes, feelings, perceptions, beliefs, roles, and

goals in life….[It is] the development of new meaning and purpose in one's life, beyond the impact of mental illness" (Anthony, 1993; Anthony et al., 2002). The Substance Abuse and Mental Health Services Administration (SAMHSA, 2012) utilizes a similar working definition for recovery that also highlights individual growth and change: "recovery is a process of change through which individuals improve their health and wellness, live self-directed lives, and strive to reach their full potential" (retrieved from http://www.samhsa.gov/recovery). Both definitions highlight the importance of having a sense of "purpose" in life as a key dimension of recovery. In addition, the above conceptualizations acknowledge that recovery is highly individualized, can occur through multiple pathways, and is supported through relationships and social networks.

Davidson and Roe (2007) describe not simply recovering *from* a serious mental illness, but recovering *in* one. Recovery is not linear, and recurrence of symptom, episodes of relapse, and other challenges and setbacks are all part of the journey (Farkas, 2007). In addition, recovery is not limited to the reduction of symptoms; it is broader and richer than that and includes the development and maintenance of positive relationships, participation in fulfilling activities, and a transformation in one's conception of self (Anthony, 1993). Yano et al. (2010) describe the process of moving from an identity as a "patient" to one of a "person," reclaiming a sense of oneself as an active agent along the way (p. 76).

Though pursuing one's educational goals has been acknowledged as an important part of individual recovery by mental health consumers, providers, and researchers working in the field of psychiatric rehabilitation (Blacklock, Benson, & Johnson, 2003; Collins & Mowbray, 2005; Megivern, Pellerito, & Mowbray, 2003), the institution of

education itself, and its potential role in fostering recovery on a broad scale remains largely unexplored. Currently little is known regarding how higher education, in particular, might facilitate and/or hinder recovery for the estimated 20% to 32% of American college students managing some form of mental illness (Eisenberg, Hunt, & Speer, 2013; Rickerson, Souma, and Burgstahler, 2004).

My operational definition for "recovery" draws from the constructs described above. In addition, I believe that mental health recovery as not just possible, but *probable* given adequate services and supports. I also conceive of recovery as a *process* (as opposed to an outcome) that often takes considerable time (read: Development), includes a shift in one's perceptions of self (read: Identity), and is reliant on supportive environments and relationships (read: Contextualism and PYD). The concept of recovery serves to tie together many of the other elements of the conceptual framework for this study. For me, recovery is deeply meaningful and highly personal; it is hope made tangible. As scholar and activist Pat Deegan has written:

> A tiny, fragile spark of hope appeared and promised that there could be something more than all this darkness…This is the mystery. This is the grace…All of the polemic and technology of psychiatry, psychology, social work, and science cannot account for the phenomenon of hope. But those of us who have recovered know that this grace is real. We lived it. It is our shared secret. (1988, p. 56)

**Chapter Two Summary**

In this chapter I have explained my understanding of what a conceptual framework is and how it scaffolds the design of a research study. I also shared a figure that represents the three major elements of the conceptual framework that I constructed for this study (p. 29). These three components entail (1) my own experiential knowledge,

(2) the pragmatic paradigm that informs my use of a mixed methods approach, and (3) several existing and complementary theories and sensitizing concepts.

Taken together, these knowledge bases and beliefs overlap and act as signposts, guiding the questions that I ask in this study, as well as the methodological choices that I employ to answer them. This conceptual framework also provides the basis for a broader social justice mission: to catalyze positive change to support the largest and least visible population of minority students in schools today – those with serious emotional behavioral disorders and psychiatric disabilities.

# CHAPTER 3

# LITERATURE REVIEW

## Chapter Overview

In this chapter, I present literature relevant to understanding the current state of youth and emerging adults with psychiatric disabilities and their educational pathways. Rather than going deeply into every possible sub-topic, I gravitate toward breadth and present literature and findings on the following: youth with "emotional disturbance" in secondary schools and related federal legislation; the prevalence and correlates of psychiatric disability in youth and emerging adults; college students with disabilities in general; and college students with psychiatric disabilities in particular.

The following additional pertinent topics will be addressed in Chapter Seven's Discussion, where qualitative and quantitative findings are linked to related existing literature: disclosure of psychiatric disabilities in educational contexts; mental health help-seeking; campus-based disability services and academic accommodations; and "Supported Education."

## Terminology and Federal Legislation Related to Youth with Disabilities

While terms such as "emotional disturbance" (ED), "emotional-behavioral disorder" (EBD), "serious mental health condition" (SMHC), "serious mental illness" (SMI), and "psychiatric disability" (PD) are often used interchangeably in both academic literature and public policy, I believe that it is important to be clear about words, labels, and their usage. Below, I take a moment to explain some of the commonalities and distinctions among these terms. First, however, it is necessary to review federal

legislation and protections for people with disabilities in general, as well as for students with disabilities in schools, in particular.

For students with disabilities, the three laws most relevant to K-12 and postsecondary education are: (1) the Rehabilitation Act (Section 504 specifically), (2) the Individuals with Disabilities Education Act (IDEA), and (3) the Americans with Disabilities Act (ADA). Prior to such legislation, students with disabilities could legally be refused admission to K-12 public schools, as well as to colleges and universities, solely on the basis of having a disability (Weiner & Wiener, 1996).

**Individuals with Disabilities Education Act (IDEA).** The Individuals with Disabilities Education Act (IDEA) (formerly called the Education for all Handicapped Children Act of 1975) is the nation's special education law; it requires that U.S. public schools "provide free and appropriate education in the least restrictive environment possible" to all eligible children with disabilities, ages 3-21. In addition, IDEA requires that public schools develop appropriate Individualized Education Programs (IEPs) for each child identified with a disability. These programs are specifically designed to address a child's needs and particular disability, and they include academic accommodations and individualized supports to ensure equal opportunities for learning. Determining a child's eligibility for special education and related services begins with a full and individual evaluation of the child. Under IDEA, this evaluation is provided free of charge in public schools (U.S. Department of Justice, 2009).

**Individual Education Program (IEP).** As described above, every student in a U.S. public school who receives special education services must have an Individualized Education Program (IEP). The IEP itself is an individualized document meant to create

an opportunity for teachers, parents, school administrators, and students to work together to improve educational results for children with disabilities. IEPs have two primary goals: (1) set reasonable learning goals for the student, and (2) explicitly state the services that the school district will provide for that student. According to the U.S. Department of Education, “the IEP is the cornerstone of a quality education for each child with a disability” (U.S. Department of Education, 2000).

Starting at age 14, a statement of post-secondary transition needs that focuses on the student’s course of study is required (e.g. participation in AP courses, or plans to enter a vocational education program). Beginning at age 16, a statement of personalized transition services to scaffold the student’s move beyond high school is composed and updated yearly (Maag & Katsiyannis, 1998). Transition planning involves “a results-oriented process” focused on improving the academic and functional achievement of the child with a disability, to facilitate the child’s preparation for postsecondary school activities (Johnson, 2005). Youth age 16 and older are invited to participate in “transition planning” meetings in an effort to position their personal goals and preferences at the center of planning for life after high school.

**Section 504 of the Rehabilitation Act of 1973.** Section 504 of the Rehabilitation Act of 1973, a broad civil rights law, prohibits discrimination on the basis of disabling conditions by programs and activities receiving or benefiting from federal financial assistance. Among other entities, the law pertains to any "local educational agency, system of vocational education, or other school system” (29 U.S.C. § 701). As applied to K-12 schools, the law broadly prohibits the denial of a publically funded education to a

child because he or she has a disability. In addition, institutions of higher education that receive federal funds must also comply with these mandates.

While the IDEA protects the subset of children and youth who have disabilities that meet the criteria for IDEA's definition of "child with a disability," many young people with disabilities do not meet that definition and are, instead, protected by Section 504. Schools comply with Section 504 by identifying students who could benefit from services; evaluating those students; and writing accommodation plans for eligible students called "504 Plans". In addition, Section 504 provides rights to students for issues outside of the school day (e.g. extracurricular activities, sports, and after school care), as well as to students in higher education who attend colleges receiving federal financial assistance, as mentioned above.

College students with 504 plans remain covered under federal nondiscrimination laws, but only recently have campus disability services offices begun to include students coming out of high school with 504 plans in the category of "students with disabilities" who are eligible for services in higher education (National Council on Disability, 2015).

**Americans with Disabilities Act (ADA).** The ADA, passed in 1990, is a wide-ranging civil rights law that prohibits discrimination on the basis of disability. It affords civil rights protections to individuals with disabilities that are like those provided to individuals on the basis of race, sex, national origin, and religion, and guarantees equal opportunity for individuals with disabilities in employment, public accommodations, transportation, state and local government services, and telecommunications. The ADA protects the rights of college students with disabilities and ensures that these students receive federally mandated and individualized "reasonable accommodations" that afford

them access to an education that is equal to their peers. (Note that while Section 504 of the Rehabilitation Act of 1973 and the ADA together ensure equal access to *postsecondary* education, Section 504 and the IDEA together safeguard against discrimination based on disability in public *K-12* schools.)

In sum, the above legislation is intended to protect students with every type of disability, including emotional-behavioral and psychiatric disabilities, from discrimination in public school settings, as well as in postsecondary education. The laws are also meant to ensure that services such as academic accommodations are provided to students with identified disabilities. Evidence shows that, on average, when appropriate services, supports, and accommodations are provided, students with disabilities are just as successful academically as are their peers without disabilities (Salzer et al., 2008).

**Emotional Disturbance.** The IDEA uses the term "emotional disturbance" (ED) to describe students with "emotional or behavioral disorders"; the latter is a special education category, as opposed to a medical, psychiatric, or psychological category of disorder. While children and youth in schools with anxiety, depression, and bipolar disorder may have DSM-V diagnoses (American Psychiatric Association, 2013) from a mental health provider, as far as schools are concerned, these students must meet separate criteria for "emotional disturbance" in order to receive special education services. IDEA defines "emotional disturbance" as follows:

> A condition exhibiting one or more of the following characteristics over a long period of time and to a marked degree that adversely affects a child's educational performance:
> (a) An inability to learn that cannot be explained by intellectual, sensory, or health factors.
> (b) An inability to build or maintain satisfactory interpersonal relationships with peers and teachers.

(c) Inappropriate types of behavior or feelings under normal circumstances.
(d) A general pervasive mood of unhappiness or depression.
(e) A tendency to develop physical symptoms or fears associated with personal or school problems." [Individuals With Disabilities Education Act, 20 U.S.C. § 1400 (2004).]

As is clear from the above criteria, in order for a student with an "emotional disturbance" to be protected under IDEA, his or her educational performance, behavior, and/or relationships in school must be adversely affected.

**Psychiatric Disability.** While *emotional disturbance* is a term specific to the field of special education, *psychiatric disability* has its roots in the medical field of psychiatry. It is used to describe a diagnosed mental illness - a condition that disrupts a person's thinking, feelings, mood, and/or ability to engage in major life activities such as learning, working, communicating, and sustaining relationships (Anthony, Cohen, Farkas, et al., 2002). Most researchers and clinicians agree upon four main categories of psychiatric disabilities: mood disorders such as depression and bipolar disorder; anxiety disorders such as generalized anxiety, obsessive compulsive disorder (OCD), and panic disorder; schizophrenia and related psychotic disorders; and personality disorders such as borderline personality disorder. The diagnosis of a psychiatric disability often occurs between the ages of 18 and 24 (Kessler et al., 2005a), a time when many emerging adults are in, or about to begin, college. (Note that details on the psychiatric disabilities mentioned above, all of which are represented in the sample of participants for this study, are provided in Appendix H.)

A key take-away from the legislation and terminology outlined above is that it is a school's responsibility to identify children with emotional disturbance in order to afford them protections and services that will support their learning and academic success.

Unfortunately, many students with diagnosed psychiatric disabilities remain "invisible" to teachers and staff at schools. For youth struggling with disorders such as depression and other "internalizing" disorders, symptoms can lead to social isolation and a lowered mood, for example, and may go unnoticed by adults at school. Many students manage to maintain decent grades and complete schoolwork despite serious mental health challenges, often struggling to navigate school and "keep up appearances" while facing changes in mood, appetite, sleep, memory, attention, and motivation. Indeed, the majority of the participants in the current study were not identified as having "emotional disturbance" in middle or high school, despite the fact that many of them experienced psychiatric hospitalizations and numerous absences from school due to their symptoms.

Another noteworthy aspect of the above legislation is that while K-12 public school personnel are legally responsible for identifying students with disabilities and providing appropriate services under the IDEA, the burden shifts to the student in higher education. Once enrolled in college, a student must self-identify as a person with a disability at his or her campus's student disability services office in order to request specific academic accommodations. According to the ADA, "reasonable accommodations" are intended to grant individuals with disabilities equal *access* to educational opportunities and services (Stodden, Whelley, Chang, & Harding, 2001); they are not required to ensure that one's particular education is of high quality, or that it leads to favorable outcomes. Here, again – at least according to the law – once students are granted *access,* they themselves are responsible for their success or failure in higher education. Because college and university students must inform campus staff if they have

a disability, provide documentation of the disability, and propose options for individualized accommodations, Stodden and Conway (2003) contend that

> "self-advocacy/self-determination skills, or the ability to understand and express one's needs and to make informed decisions based upon those needs, is considered to be one of the most important skills for students with disabilities to have *before* beginning their postsecondary experience" (p. 4). (Italics added for emphasis.)

**Psychiatric Disabilities in Youth: Prevalence and Correlates**

**Prevalence.** Serious mental health challenges such as mood, anxiety, and psychotic disorders are common in both adults and youth. In fact, around the globe, mental health conditions are the leading cause of disability and morbidity in youth and young adults. Adolescence and young adulthood are the period of peak prevalence and incidence for most mental disorders (Merikangas et al., 2010; Kessler et al., 2007a), with half of all mental health problems beginning by age 14 and three-quarters by age 24 (Kessler et al., 2005a; Kessler et al., 2007b). Indeed, one in four Americans will be diagnosed with a mental illness in his or her lifetime, with roughly half of these manifesting by mid-adolescence (Gould, Greenberg, Velting & Shaffer, 2003).

Of the 74.5 million children in the Unites States today, an estimated 17.1 million, or approximately 23%, have or have had a psychiatric disorder (Brauner & Stephens, 2006; Merkingas, 2010; Kessler et al., 2005a). This is more than the number of children with cancer, diabetes, and AIDS combined (Child Mind Institute, 2015). Approximately one in five youth ages 0-18 meet the criteria for a diagnosable mental, emotional or behavioral disorder, and one in ten has a mental health problem so severe that it impairs

functioning at home, in school, or in the community (United States, President's New Freedom Commission on Mental Health, 2003). Unfortunately, approximately 75% of these youth do not receive any services at all (Kataoka, Zhang, & Wells, 2002); among those who do, the vast majority (70-80%) receive services and supports in schools from counselors, social workers, and school psychologists (Burns, Costello, Angold et al., 1995; Rones & Hoagwood, 2000).

**Common Outcomes and Correlates.** Despite the magnitude of the problem, lack of awareness and entrenched stigma keep the majority of young people with mental health needs from getting help (Merikangas, 2010). Children and adolescents with psychiatric disabilities are at risk for academic failure, physical health challenges throughout life, involvement with the juvenile justice system, and even heightened risk of suicide (Child Mind Institute, 2015).

***Educational outcomes.*** Mental health disorders in young people pose a major threat to school success because students with emotional disturbance (ED) who do not receive adequate services and supports often perform dramatically worse than their peers with and without disabilities in a range of academic areas (Wagner, Kutash, Duchnowski, Epstein, & Sumi, 2005). In fact, "the academic deficits experienced by students with EBDs are often so severe that their academic profiles tend to resemble those of students with learning disabilities (Lane, Carter, Pierson, & Glaeser, 2006; Nelson, Benner, Lane, & Smith, 2004)" (Maggin, Wehby, & Gilmour, 2016, p. 138). Nelson and colleagues (2004) found that K-12 students with emotional/behavioral disorders show "large deficits across all of the (academic) content areas," with deficits appearing stable or often worsening over time (p. 59). Reid and colleagues (2004) conducted a meta-analysis of the

academic status of students with ED and found that disorders such as depression and anxiety in youth are "characterized by a range of behaviors that adversely affect a child's academic performance." The observed overall effect size of -.64 across numerous studies indicates that students with ED have significant deficits in academic achievement, performing at significantly lower levels than their peers without such disabilities across subject matter and settings.

In addition to having lower grades and academic achievement, on average, than their peers, students with ED also have higher dropout rates than any other group of students with disabilities (Newman et al., 2011). When they do not receive adequate supports, they are more likely to become disconnected from school, putting them at heightened risk for school leaving. In fact, over half of students aged 14 or older with ED never finish high school. This is the highest dropout rate of *any* disability group (US Dept of Education, 2005; Wagner & Newman, 2012). Even among students with mental health conditions who *are* served by special education in public schools, 37% drop out, the highest dropout rate of any group of students (U.S. Department of Education, 2014).

Among all students who do not complete high school, 36% are students with learning disabilities and a full 59% are students with emotional and behavioral disabilities (Blackorby & Wagner, 1996; Vander Stoep, Weiss, Saldanha, Cheney, & Cohen, 2003). Such disengaged and out-of-school youth have increased rates of arrest and incarceration (Egyed, McIntosh, & Bull, 1998; Nolan, 2011). Even youth with psychiatric disabilities who *are* able to complete high school face diminished odds of attaining employment and increased risk of incarceration (Egyed, McIntosh & Bull, 1998; Nolan, 2011). In addition, the 11% of youth and young adults with ED and psychiatric disabilities who *do* complete

secondary school and pursue higher education (Wagner & Newman, 2012) experience longer delays in entering college than their peers (Newman et al., 2011), and 86% will eventually leave college without completing a degree (Kessler, Foster, Saunders, and Stang, 1995). This is the highest college dropout rate of any group of minority students (Salzer, Wick, & Rogers, 2008), and it is nearly twice the general college dropout rate, which is approximately 44% (Symonds, Schwartz, & Ferguson, 2011). Even among college students *with* disabilities, students with psychiatric disabilities are the least likely of all sub-groups – including developmental, learning, and physical disabilities – to persist in college (Newman et al., 2011).

***Employment and socio-economic correlates*.** It is well established that lack of adequate mental health services for adolescents and young adults has a significant and negative impact on the individual youth affected, as well as on society as a whole. In addition to academic difficulties, unmet mental health needs for youth and young adults are associated with later lost productivity at work, increased risk of poverty, housing instability, and even premature death (Gibb, Ferguson, & Horwood, 2010; Maulik, Mendelson, & Tandon, 2010; Wagner & Davis, 2006; World Health Organization, 2001).

In both educational and employment domains, youth with psychiatric disabilities fare worse than their peers, both with and without disabilities (Maggin, Wehby, & Gilmour, 2016, p. 138). In a national study that included individuals out of high school for up to eight years, students with psychiatric disabilities were found to have a post-secondary school employment rate of only 50% (Newman et al., 2011; Wagner & Newman 2012). The young adults who are able to find work face low-wage and primarily part-time positions (Wagner & Newman, 2012), and these poor economic outcomes

persist into adulthood. Indeed, adults living with serious mental illness make up a large percentage of people living in poverty in the U.S., and limited educational and economic opportunities in youth predict little or no economic progress across the lifespan (Baron & Salzer, 2002).

As Ellison, Rogers, and Costa (2013) write:

> Serious mental health conditions (SMHC) translate into functional limitations that impact educational performance, such as sustaining concentration, screening out stimuli, maintaining stamina, handling time pressure and multiple tasks, interacting with others, and test anxiety (Souma et al., 2006). When that onset occurs at a young adult age (Corrigan, Barr, Driscoll, & Boyle, 2008; Nuechterlein et al., 2008; Waghorn, Still, Chant, & Whiteford, 2004) or during adolescence (Wagner, Newman, Cameto et al., 2006), disruptions to educational attainment and vocational plans can result in a trajectory of unemployment disability, and poverty (p. 2).

Simply put, without recognizing and addressing the essential role of mental health in education and career development, pervasive inequities in opportunity continue thoughout the lifespan (Adelman & Taylor, 2010; Basch, 2010).

***Juvenile Justice involvement.*** Several decades ago, the majority of people living with serious mental illness in the United States were in state-run psychiatric institutions. However, a national push for "de-institutionalization" in the 1970s and 1980s left all but a handful of public psychiatric facilities open, with the vast majority of patients returned to communities (Torrey, 1997). The sad legacy of what was once a well-intentioned endeavor to shutter dehumanizing and dilapidated "warehouses" for the most marginalized among us has resulted in many ways in a broken, under-funded, and disjointed mental health system where people in need of services, care and housing instead are arrested for crimes related to their symptoms (e.g., indecent exposure, disturbing the peace, petty theft, or trespassing) (Lamb & Weinberger, 2005). After

spending an average of thirty days in county jails, such patients are generally released to cycle through the process of homelessness-arrest-incarceration and return-to-society all over again (Draine, Wilson, Metraux, Hadley, & Evans, 2010).

Unfortunately, juveniles with untreated mental health disorders face an equally bleak fate (U.S. House of Representatives, 2004). Youth in the juvenile justice system have substantially higher rates of mental health disorders than youth in the general population (Otto, Greenstein, Johnson, & Friedman, 1992). While serious psychiatric disorders affect between 7% and 12% of the general youth population (Roberts, Attkisson, & Rosenblatt, 1998), such disorders occur in 60% to 80% of youth in detention (Cauffman, 2004; Domalanta, Risser, Roberts, & Risser, 2003; Otto et al., 1992; Teplin, et al., 2002). In addition, 50% to 60% of youth in detention meet criteria for two or more disorders (Abram, Teplin, McClelland, et al., 2003). A congressional committee tasked with studying the issue concluded that approximately 2,000 youth who have not committed any crime are incarcerated every day simply because community mental health services are unavailable to them (U.S. House of Representatives Committee on Government Reform, 2004). Because schools provide the majority of mental health services to youth in the U.S., the afore-mentioned findings suggest that a major factor in the "school to prison pipeline" is not receiving adequate – or any – services in schools to address mental health challenges and other barriers to learning.

***Health correlates.*** In addition to educational, employment, and incarceration related correlates to serious mental health conditions in youth and young adulthood, there are also significant associations with poor health, above and beyond psychiatric disability. Evidence shows that individuals with serious mental illness face increased

rates of chronic medical conditions such as diabetes; asthma; cardiovascular, viral, respiratory and musculoskeletal diseases; and obesity-related cancers (Charlson et al., 2015; De Hert et al., 2011). Because of these disparities, adults in the U.S. living with serious mental illnesses such as major depression, bipolar disorder, and schizophrenia die on average 25 years earlier than same-aged peers. This discrepancy is largely due to socio-economic disparities in access to care for the above treatable medical conditions, as well as lifestyle factors that increase risk for chronic illness such as physical inactivity, smoking, excessive drinking, and insufficient sleep (Chapman, Perry, & Strine, 2005; De Hert et al., 2011).

***Suicide.*** Suicide is the 10th leading cause of death among adults in the U.S. and the 3rd leading cause of death among people aged 10-24 (CDC, 2015). Although the vast majority of people who experience a mental illness do not die by suicide, mental illnesses are "the most powerful and clinically useful predictors of suicide" (Rihmer, 2007). Among people of all ages who do commit suicide, more than 90 percent have a diagnosable mental disorder (Shaffer & Craft, 1999).

Regarding youth specifically, approximately 4,600 people between the ages of 10 and 24 die by suicide in the U.S. every year (CDC, 2015). Having suicidal thoughts is the strongest predictor of making an attempt, and in 2014, emerging adults ages 18 to 25 were more likely than adults in any other age group to have serious thoughts of suicide, to have made suicide plans, or to have attempted suicide (Kann, McManus, & Harris, et al., 2016). Among adults aged 18-22 years, similar percentages of full-time college students and non-college going peers had suicidal thoughts (8.0 and 8.7%, respectively) or made suicide plans (2.4 and 3.1%) (SAMHSA, 2013).

Regarding suicide on college campuses, estimated rates for making a suicide plan are as high as one in twelve U.S. college students, with 7.1 deaths by suicide per 100,000 college students ages 20-24 (Ellison, Rogers, & Costa, 2013, p. 30). And among high schools students in 2015, more than 17% (approximately 2.5 million American students) seriously considered suicide, more than 13% made a suicide plan, and more than 8% attempted suicide (Kann et al., 2016). The role of major depression in suicide is particularly strong, with depression believed to be present in 65-90% of all cases (Krug, Mercy, Dahlberg, & Ziwi, 2002).

***A reminder of hope.*** Despite the above findings regarding significant disparities and grave outcomes for youth and adults with mental illness, it is important to note that the vast majority of people living with depression, anxiety, and bipolar disorder do, in fact recover and lead full lives, attend school, work, have families, and are engaged members of their communities. Even with schizophrenia, considered the most severe and debilitating of all mental illnesses, when youth and adults receive high-quality and ongoing treatment and social supports, the majority can manage their symptoms well, participate in society, and experience significant recovery (Crumlish et al., 2009; Harrow & Jobe, 2007; Lambert et al., 2008; Warner, 2004).

**College Students with Disabilities**

More students with disabilities of all types are enrolling in higher education than ever before. The National Council on Disability (2015) found that, as of 2012, 11% of undergraduate students in the U.S (approximately 2 million people) were identified as having a disability, with learning disabilities the most common type reported. Students with disabilities are attending postsecondary education at rates similar to their

nondisabled students, yet their completion rates are much lower (Newman et al., 2011; Williamson, Robertson & Casey, 2010). Only 34 percent of college students with disabilities will attain a four-year degree in eight years, while rates for non-disabled students are between 51 and 52 percent (Newman et al., 2011).

**Accommodations.**

In their review, Stodden and Conway (2003) found that although postsecondary educational services, supports, and accommodations available to students with disabilities vary significantly across states as well as from campus-to-campus, they do share several characteristics. Services are generally not explicitly linked to programs or pedagogy and they tend to emphasize "advocacy, informational services, and remediation of course content" rather than "support for independent learning and self-reliance" (p. 26). Access to education is meant to be ensured through the provision of 'academic adjustments and reasonable modifications,

and auxiliary aides and services' in the form of 'reasonable accommodation' (Lee, 1996; Thomas, 2000)" (Stodden & Conway, 2003, p. 26). Academic adjustments often take the form of extra time on tests or for assignments, while auxiliary aides afford access to course content and interactions for students with sensory impairments (e.g. a sign language interpreter for students who are deaf).

Despite the fact that such accommodations must legally be provided free of charge to eligible students, the vast majority of college students who might benefit from them do not request them. While 87 percent of students with learning disabilities in K-12 received academic accommodations, only 19 percent of these students continue to receive support in higher education (National Council on Disability, 2015). Newman et al.

(2011) found that two-thirds of special education students in secondary school no longer identify as "disabled" after high school. There are likely numerous factors related to why incoming students with disabilities do not access accommodations, but issues of identity may be paramount.

**Overview of college students with psychiatric disabilities.** Just as college students across disabilities are enrolling in American institutions of higher education in increasing numbers, so too, are students with psychiatric disabilities (Gallagher, 2012). It is common for emerging adult college students to face challenges related to autonomy (e.g. leaving home for the first time), relatedness (e.g. renegotiating relationships with parents), and "moratoria" (e.g. exploring various commitments to career or romantic partners) as they adjust to higher education. However, students with psychiatric disabilities often face additional demands. Symptoms can result in functional limitations related to short-term memory, critical thinking, and executive functioning (Hartley, 2010). In addition, side effects from psychiatric medications can reduce students' attention, concentration, and energy levels (Weiner & Wiener, 1996). Taken together, these complications can lead to decreased feelings of academic self-confidence and efficacy for students (Hartley, 2010). In addition to such in*tra*personal challenges, students with psychiatric disabilities also face numerous in*ter*personal impediments, such as stigma and discrimination from faculty and peers, and conflicted peer relationships (Hartley, 2010).

The published literature related to students with mental illness on college campuses is growing, and currently the majority addresses the following related topics: (1) prevalence of various mental health disorders on college campuses and common outcomes for students affected by them; (2) student transitions and adaptation to campus

life (including a limited but growing number of qualitative studies exploring the lived experiences of college students with psychiatric disabilities); (3) attitudes and behaviors related to help-seeking for and disclosure of mental health challenges in educational contexts; (4) typical campus and institutional services and supports – including academic accommodations - for students with psychiatric disabilities; (5) faculty and staff perceptions of and reactions to students with mental illness; and (6) the effectiveness of "Supported Education" programs to aide college students with mental illness. In the remainder of this chapter, I will focus on number 1 above (prevalence and common outcomes), leaving sub-topics 2 through 6 for Chapter Seven (Synthesis & Discussion), where I present merged qualitative and quantitative findings and discuss them in the context of existing literature.

**Prevalence and Common Educational Outcomes.** Prevalence rates for college students with mental illness range from 9% to 18% of the college-going population, and these rates appear to be increasing (Ellison et al., 2013). In a national survey of college counseling center directors, 88% reported an increase in severe psychological problems among their clientele (Gallagher et al., 2012). A 2011 qualitative study interviewed campus counseling center administrators and found an increase in the severity of mental health concerns among students, as well as increased demand for campus-based counseling and psychiatric services (Watkins, Hunt, & Eisenberg, 2011). These increases have been attributed in part to improvements in mental health treatment, advancements in medication, and better access to effective services (Ellison et al., 2013, p. 2).

Poor mental health negatively affects students' academic performance, as well as retention and program completion (Oswalt & Wyatt, 2013). Collins and Mowbray (2005)

found that a full 86% of students with psychiatric disabilities leave college prior to completing their degrees. The University of Michigan's annual "Healthy Minds" survey reveals that depression has emerged as the primary reason for college attrition (Eisenberg, Golberstein, & Hunt, 2009; Pleskac, 2011). In addition, the mood disorder was found to be a significant predictor of lowered academic achievement for students who do remain in school, and proved a particularly strong risk factor among students who also have anxiety disorders. Indeed, depression and anxiety are consistently listed among the primary factors negatively affecting academic performance.

Another recent survey of over 200,000 incoming freshman at four-year institutions across the country indicates that students' emotional health is at its lowest point since the survey began collecting data 25 years ago (Pryor et al., 2010). And a survey by the American College Health Association (2013) reports that nearly half of college students have felt " hopeless" at least once in the previous 12 months, with nearly a third feeling "so depressed that it was difficult to function."

In addition to the above studies that sample all college students at participating universities in an effort to estimate the prevalence of students meeting criteria for DSM diagnoses, there are several studies of college students already identifying as having a mental illness. Salzer's (2008) study of 450 current and former college students with mental illness recruited from 300 colleges and universities around the country found that these students report less engagement on campus, have less satisfying and fewer social relationships than peers, and experience lower graduation rates. And students who do remain in school while managing psychiatric disabilities report lower quality of life and

higher levels of isolation, both of which have been found to negatively influence academic achievement (Herts, Wallis, & Maslow, 2014).

The National Alliance on Mental Illness administered a national survey and solicited responses from both current and former college students with mental illness, as well (Gruttadaro & Crudo, 2012). This study included 765 people who identified as having a serious mental illness, and who had been enrolled in college within the last five years. Findings show that sixty-four percent of respondents no longer attending college at the time of the survey had left school "for a mental health-related reason." In addition, 45% of those who stopped attending college because of a mental health reason did not receive accommodations, and 50% did not access mental health services and supports. When asked about disclosing a mental health diagnosis to one's college or university, half of respondents said "yes" and the other half said "no." Though the survey findings include some reasons for people's behaviors surrounding disclosure (many students chose to disclose to secure academic accommodations), the survey does not offer insight into why students disclosed, to whom, and how recipients reacted.

There is a moderate and growing body of literature exploring the lived experiences of students with mental illness (see Knis-Matthews, 2007; Kranke et al., 2013; Stein 2012, 2013 and 2014; Weiner & Wiener, 1996), and some of this literature is reviewed in Chapter 7 as part of the discussion of qualitative findings for the current study. In brief, students report numerous barriers and challenges to pursuing their college degrees. These include difficulties transitioning into higher education (Fowler, 2008; Stein, 2012; Werner, 2001); prevalent stigma (Michaels et al., 2015; Tinklin, Riddell, & Wilson, 2005; Weiner & Wiener, 1996) and social isolation (Ennals, Fossey, & Howie,

2015; Jones, Brown, Keys, & Salzer, 2015; Megivern, Pellerito, & Mowbray, 2003; Tinklin et al., 2005); educational progress hindered by episodes of recurrent or exacerbated symptoms and/or side effects from medication (Markoulakis & Kirsch, 2013); lack of service coordination both within and outside of the college or university; concerns related to seeking help at campus-based counseling facilities (Mowbray et al., 2006) and student disability services (McEwan & Downie, 2013); protracted wait times at college mental health facilities when they do seek services (Stecker, 2004); concerns related to mental health disclosures in various contexts (Buchholz, Aylward, McKenzie, & Corrigan, 2015; Ennals et al., 2015; Hyman, 2008; Kranke et al., 2013; Nawabi, 2004; Venville & Street, 2012; Venville, Street, & Fossey, 2014); and a general lack of awareness and understanding among campus faculty, staff and other students (Martin, 2010; Padron, 2006).

In addition to the focus on barriers to school success, there are also several recent studies that report strengths-based or positive findings for college students with mental illness. In a qualitative interview-based study on the meaning of higher education for students with mental illness, Knis-Matthews (2007) found that a primary recurrent theme in the lives of the study participants was education as a way to find "purpose" and "transition into other life roles." Kranke et al. (2013) found that some students report feeling "empowered" when utilizing psychiatric treatment (including medication) and that engaging in this way in their own recovery supports their educational and social goals.

## Gaps in the Literature

Despite the growing research on prevalence rates of mental illness on college campuses, and the burgeoning body of work on students' experiences in college, a sense of their participation in school prior to college matriculation is missing. Currently, there are no studies of how youth with psychiatric disabilities successfully navigate and complete high school, nor does any research exist on how this population plans for the transition to and journey through college. In addition, all of the existing studies are cross-sectional, with developmental trajectories and change over time not yet explored. And, finally, the issue of disclosure of a psychiatric disability in educational contexts has only been investigated to a limited degree, as will be discussed further in Chapter Seven (Corrigan et al., 2015; Nawabi, 2004; Rusch et al., 2014; Venville & Street, 2012; Venville, Street, & Fossey, 2014).

## Chapter Three Summary

This chapter began with a review of terminology and federal legislation related to youth with emotional disturbance and to young adult college students with psychiatric disabilities. Next, I presented literature relevant to understanding the influence of mental health on young people's educational pathways. Following that, I presented selected literature relevant to the prevalence and correlates of psychiatric disability in youth and emerging adults, to college students with disabilities in general, and to students with psychiatric disabilities in particular. I ended with a brief description of gaps in the current literature base.

# CHAPTER 4

# RESEARCH METHODOLOGY AND DESIGN

## Chapter Overview

In this chapter I describe the research questions for this study, as well as the specific methods that I employed in both the collection and analysis of the data. Following this, I describe the initial wave of qualitative data collection and the preliminary analysis of these. Next, details on the development, construction, and implementation of the online survey are provided; after that, I describe the second wave of qualitative data collection and analysis. The chapter closes with an explanation of my process for integrating the qualitative and quantitative data and analyses, namely the use of a side-by-side joint display (Creswell, 2015, p. 85).

## Initial Research Questions Revisited

RQ #1: What is the process of preparation for and transition to and through higher education for emerging adults with psychiatric disabilities (PDs)?

Sub-questions:

1.a How do adolescent high school students with PDs prepare for college?

1.b What are these students' experiences of social and academic integration in college over time?

RQ #2: To whom and why do youth and emerging adults (EAs) with PDs make mental health disclosures in educational contexts?

Sub-questions:

2.a. Do these disclosures change as students move from high school to college?

2.b. What are others' reactions to students' mental health disclosures in college?

RQ #3: What are the relationships among disclosure, institutional integration, and recovery for EA college students w/ PDs?

Sub-questions:

3.a. Does psychiatric disability disclosure in high school predict disclosure in college?

3.b. Does psychiatric disability disclosure in college predict use of campus-based counseling or psychological services?

3.c. Does psychiatric disability disclosure in college predict use of Student Disability Services on campus?

3.d. Is psychiatric disability disclosure in college associated with institutional integration?

3.e. Is psychiatric disability disclosure in college associated with recovery?

3.f. Is institutional integration associated with recovery?

**Description of Research Design**

Drawing from Bryman's (2006) typology of reasons for "mixing" in mixed methods research, as cited by Creswell and Plano Clark (2011), this study incorporated both qualitative and quantitative data for the following purposes: triangulation, completeness, process, in order to address different research questions, explanation, instrument development, and context. The first reason "refers to the traditional view that quantitative and qualitative research might be combined to triangulate findings in order that they may be mutually corroborated"; completeness "refers to the notion that the

research can bring together a more comprehensive account of the area of inquiry"; process "refers to when quantitative research provides an account of structures in social life but qualitative research provides a sense of process"; different research questions refers to the argument that quantitative and qualitative research can address distinct questions; explanation refers to when findings from one approach are used to help explain findings generated by the other; instrument development refers to contexts in which qualitative research is employed to develop questionnaire and scale items; and context refers to qualitative research "providing contextual understanding coupled with either generalizable, externally valid findings or broad relationships among variables uncovered through a survey" (Creswell & Plano Clark, 2011, p. 62).

As described in the overview of methodology in Chapter One (pages 14 through 17), the overarching design of this study is exploratory sequential mixed methods (Creswell, 2014), meaning that the qualitative data were collected and analyzed first, followed by the quantitative data. In this design, I collected and analyzed the qualitative data first, and then utilized findings to inform the development of a survey. Next, I collected quantitative data through the implementation of an anonymous online survey in order to answer questions about the relationship among variables identified in the first qualitative phase ("disclosure," "integration," and "recovery"), as well as to investigate high school and college experiences with a larger sample. And in the final phase of the study, I collected a second wave of qualitative data to assess change over time since the first wave of qualitative data collection, and to ensure a comprehensive understanding of the process of college readiness and transition for students with psychiatric disabilities.

Given its multiple methods employed over a calendar year, I will describe the three primary phases of the study sequentially (qualitative data collection at time 1 and preliminary analysis; survey development and then quantitative data collection and analysis; and - finally - qualitative data college at time 2 and analysis) below.

**First Qualitative Strand of Study**

**Participant sampling.** After receiving approval to conduct the study from the Institutional Review Board of the University of Pennsylvania (please see Appendix A), I recruited participants for the qualitative strand of the study. I knew that I wanted a purposive sample (Patton, 2002) comprised of participants who varied on a wide range of characteristics (e.g., gender, age, race and ethnicity, psychiatric disability and treatment history, and type of college or university currently attending) in order to transcend differences across participants and increase trustworthiness and credibility. I also understood that I could not know at the outset exactly how many participants I would, ultimately, need to recruit for individual semi-structured interviews, but anticipated speaking with at least 15-20 students before reaching a point of theoretical "saturation" (Bowen, 2008).

**Recruitment.** Participants for the qualitative strand of the study were recruited via an IRB-approved study announcement and recruitment flier through online youth and young adult organizations related to mental health, mental illness, and recovery; national non-profit organizations related to psychiatric rehabilitation, education, and/or advocacy; college campus-based chapters of national mental health organizations, and various other student-run and campus-based clubs and organizations that do work related to mental health awareness, education, and advocacy. (See Appendix B for a copy of the flier used

to recruit interview participants, and Appendix C for a list of online sites that I contacted regarding recruiting members.) Prospective participants were screened for suitability according to the following inclusion criteria: (1) age 18-25, (2) currently attending a U.S. 2- or 4-year college or university part- or full-time, (3) has a self-reported mood, anxiety, and/or psychotic disorder that first manifested prior to beginning college, and (4) is able and willing to discuss his or her experience in an individual face-to-face interview.

**Figure 4.1.1** Detailed Procedural Diagram – Longitudinal Exploratory Sequential MM design

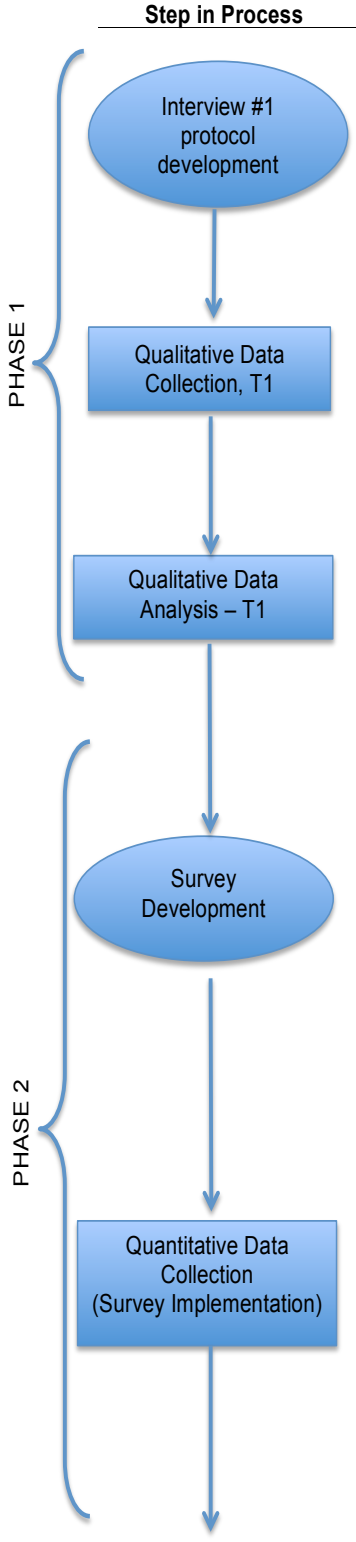
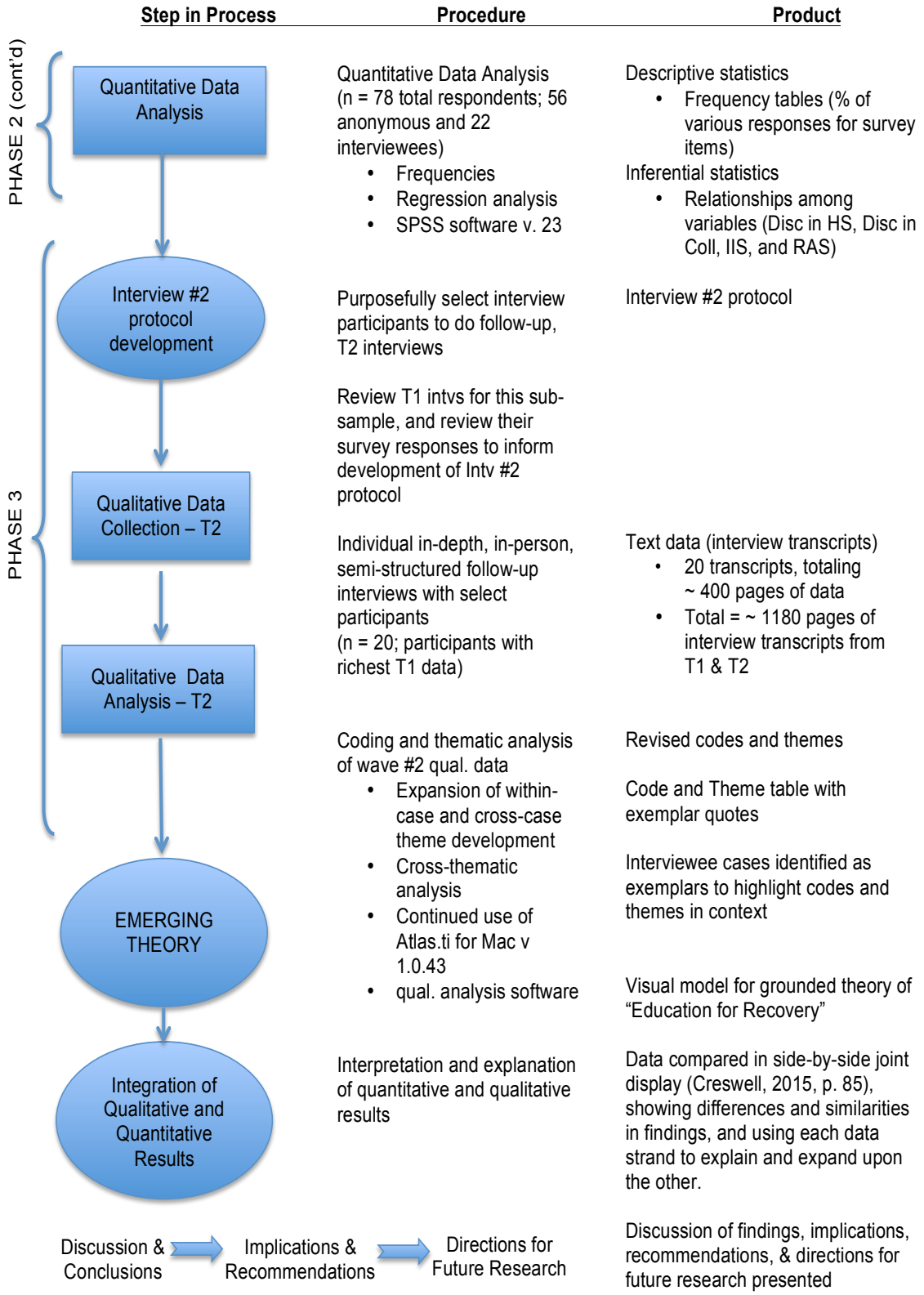


**Figure 4.1.2** Detailed Procedural Diagram (cont'd)



**Time 1 interview preparation and procedure.** Interested prospective participants contacted me via email after seeing the recruitment flier for the study. I then provided them with an explanation of the nature and purpose of the study in print (see Appendix D, the interviewee consent form). The students were asked to review this document, and then to contact me again via telephone if they remained interested in participation. During the preliminary phone conversation, I shared with the potential participants that I have my own lived experience with mental illness and recovery. I did not divulge specific details of my history, treatment, or recovery, but simply said "I think you should know that I had anorexia and depression in high school. Fortunately, I have fully recovered from the eating disorder and have not had a relapse; however, depression is something that I have been living with and managing for many years." If the young person had specific questions about my history, I answered these, but did not dwell on the topic, circling back to details regarding the current study.

Next, I encouraged the potential participants to ask any questions that they had about the study and what participation would entail. I then read through the study information sheet and consent form with them, and asked if they had any specific questions after reviewing each section together. Then, I confirmed with each potential participant that he or she was between the ages of 18 and 25, currently attending a college or university, and living with a mood, anxiety, or psychotic disorder that was first identified prior to starting college. At this point, if the potential participant agreed to proceed, we scheduled a time and date for an in-person interview. (*Note that all first-round interviews were conducted in person at a location of the participant's choosing,

with the exception of two students who live in California and Indiana respectively. These two students were interviewed at each point in time over the phone.)

I collected written informed consent prior to conducting each interview, and this entailed reviewing the voluntary nature of participation, permission to withdraw from the study at any time, freedom to choose not to answer any questions, and methods used to ensure anonymity and confidentiality, such as removing identifying information from transcripts and creating pseudonyms for all participants.

To capture the rich descriptions and context of each participant's experience, I developed an "Interview Summary Form" (see Appendix E) to collect basic background, demographic, and educational information about each participants. I also created a semi-structured interview protocol (see Appendix F) for the first round of interviews. Open-ended interview questions addressed three key areas of inquiry: (1) preparation for and expectations of college, (2) actual transitions to and through college and (3) decisions and experiences related to psychiatric disability disclosures in educational contexts. Each of these three main sections of the Time 1 interview was broken down further into sub-sections to explore in more depth.

Notably, neither the Interview Summary Form nor the interview protocol addressed suicide directly, thus suicide was only introduced in the interview if the topic was raised by the participant. That said, four of the 26 interview participants (15%) described having had suicidal thoughts, and an additional five, or 19% (all of whom are female) described at least one actual suicide attempt in her initial interview. Together, nine interviewees (34.6%) described struggling with suicidal thoughts and/or actions.

**Approach to the interviews.**

***Being an "insider."*** I believe that my position as "insider" helped to facilitate trust and confidence in my evolving relationships with the interview participants. Disclosing some of my own experiences afforded me easier entrée to many youth and young adult mental health organizations, both in-person and online, and this no doubt helped with participant recruitment. With the badge of "insider" (albeit one more than twenty years older than the study participants), I was granted acceptance and was trusted, I believe, much earlier in the recruitment process than I might have been otherwise.

Sharing some of my own mental health history prior to the interviews was also an intentional part of my approach. I believe that it helped to explain why I was doing this study in the first place, while also adding credence to the idea that I was an ally and would do my best to honor participants' stories, respect their privacy, and communicate their experiences in a way that might help other young people like themselves.

For me, disclosing was both a practical move and an ethical one. It helped to establish rapport with the interview participants, but it also made manifest an approach to research that I hold dear: namely, that I will only ever ask participants to engage in the process with the same candor that I would, while also never asking anything of them that I, myself, would not feel comfortable doing. Regarding the important relationship between researcher and research participants in qualitative work, Clandinin and Murphy (2009) explain,

> we speak to our participants and ourselves to fulfill the relational responsibilities of representing our co-constructive experiences. The priority in composing research texts is not, first and foremost, to tell a good story; the priority is to compose research texts *in relation* with the lives of our participants and ourselves (p. 61, italics added for emphasis).

I agree, but would add that I don't believe the goals of telling a good story and composing texts that authentically depict one's relationship with study participants are mutually exclusive goals. Indeed, I aspire to them both equally. That said, my priority to be *in relation* with the study participants was and remains to ensure that they felt heard, supported, and respected. As the late, great Maya Angelou said, "…people will forget what you said, people will forget what you did, but people will never forget how you made them feel." My hope is that each of our interactions left the participants feeling empowered.

***Conducting the interviews as a "well-informed traveller."*** I employed the "problem-centred interview" (PCI) approach (Witzel & Reiter, 2012) for all 26 of my interviews. Such interviews not only acknowledge deductive and inductive modes of reasoning but are, in fact, *dependent* upon these seemingly contradictory sources of knowledge, thus are aligned with the use of mixed methods in this study. By design, PCIs give equal weight to both the researcher's prior academic and theoretical knowledge, and to participants' prior practical and "everyday" knowledge. Thus, rather than situating a priori theories and past empirical findings in opposition to open-ended narratives, the PCI values both approaches equally.

The dialogue between an interviewer and a study participant in PCI is meant to be egalitarian, a conversation predicated on trust in which the meaning ascribed to a socially relevant research question (or "problem") is re-constructed collaboratively. Using the metaphor of a "well-informed traveller" the researcher openly acknowledges and strategically uses his or her prior knowledge (deductive reasoning) in order to prepare for

an interview and actively engage with participants and their meaning-making (inductive reasoning).

PCI encourages interviewers to engage in a*ctive listening* with open-ended queries and more specific follow-up "clarifying" questions based on knowledge of the field. Such prompts are meant to stimulate participants' memories, narratives, and thoughts; in this way, participants are involved in a process of *active understanding*, with the interview helping to deepen their own knowledge of the "problem" at the same time that the researcher's understanding is enhanced.

In the semi-structured interviews for this study, I did my best to adopt the role of a "well-informed traveller." First, I developed a "sensitizing framework" for the interviews that incorporated my prior knowledge of emerging adult development, psychiatric disabilities, and educational trajectories; next, I used this to create a discussion guide. I then explained to study participants that I had read a lot about the topic at hand (emerging adults with psychiatric disabilities transitioning into college), and that I have my own lived experience, but that they have their own unique experience and expertise that I hoped to learn about in our conversations. My interviews were certainly not perfect, but many of them ended with participants remarking that they had enjoyed the process and had thought about an aspect of their own mental health, recovery, and college experiences in a new way because of our dialogue. I like to think that in every instance, participants and I learned something from and with each other, and ended our conversations with new knowledge created together.

**Ethical Considerations.** Every research study involves ethical considerations, and when working with people who are particularly vulnerable – such as young adults

with psychiatric disabilities – proceeding in an ethical manner is essential to ensure that study participants are in no way harmed through their participation. This study was conducted carefully and thoughtfully in an effort to minimize potential risk to the participants. Each interview was conducted in a private location of the interviewee's choice and we made sure that no one could overhear the interview. Prior to each interview, I described the purpose of the study to participants both verbally and in writing (see Appendix D, participant consent form). I was explicit that the students' participation was entirely voluntary and that they could choose to withdraw from the study at any time, and/or could choose to not answer any interview question with which they were not comfortable. Participants were encouraged to ask questions and were given the option to stop the digital audio recorder or end the interview at any time.

Participants were told that excerpts of their interview would be used in the written report for this study, but that their names would not be used. Instead, a pseudonym of their choosing would be used in every written document and publication related to the study. And, finally, I was the only person to listen to the digital audio recordings of the interviews, and they remain securely stored on a password-protected server.

Prior to each interview, I found the name, location, hours, and phone number for the on-campus counseling centers at each of the schools that the participants attend. In the event that any sort of crisis took place during the interview or that a participant became upset during our interaction, I was prepared to contact local professionals on his or her campus for assistance. In addition, I told each interview participant at the beginning of the interview that if our conversation was triggering in away that, that we could walk over to the counseling center together and ask to speak with a staffer. I also

gave each interview participant a written copy of the contact information for their campus' counseling center, in the event that they became upset *after* our interview, due to reflecting on their pasts. Fortunately, none of the interview participants became agitated during the interviews, none requested to end the interview early, and – to my knowledge – none sought counseling support afterwards specifically because of the interview.

**Description of participants**

The final qualitative sample size of 26 emerging adult college students was based on saturation, or the point at which no new data emerged in an interview in comparison to data from all previous interviews (Bowen, 2008). By the time I had interviewed the first 20 participants and begun to code these transcripts, it was becoming clear that certain themes and experiences were emerging as common across the participants. I decided to interview several more students to make sure that this was the case, and by the time that I had interviewed 26, I was confident that no new concepts would emerge in subsequent interviews with new participants.

It is important to note that I include all 26 interview participants in the qualitative analysis strand of this study, but I only include 22 of these participants in the quantitative strand. This is because the first 22 interviewees also completed the survey in phase 2 of the study, as well as a second interview with me in phase 3 of the study.

The interviewees at Time 1 consist of 22 women and 4 men ranging in age from 18 to 25, with a mean age of 20.4 years (see Table 4.1). Sixteen participants (84.6%) are Caucasian, 4 are African-American (15.4%), 2 are Latino (7.7%), 3 are multi-racial (11.5%), and 1 identifies as "other." Regarding mental health diagnoses: 21 participants (80.8%) report living with a mood disorder such as Major Depression or Bipolar

Disorder; 14 (53.8%) live with an anxiety disorder such as Generalized Anxiety Disorder, OCD, or Panic Disorder; and 2 (7.7%) live with schizophrenia. Fourteen of the 26 interview participants (53.8%) report having two or more serious mental health conditions, with other disorders including eating disorders and personality disorders. (See Appendix H – Brief Descriptions of the psychiatric disabilities and diagnoses represented in both the qualitative and quantitative arms of the study.)

Interviewees attended various types of secondary schools, with 18 attending traditional public high schools, 9 attending private schools, 1 attending a religious school, 1 attending a therapeutic day school for youth with emotional-behavioral disorders, and 1 attending a school identified as "other." The latter was a "home in hospital" situation where the student completed his public school curriculum at home and online, scheduling his school work around his medical and therapy sessions. The number of types of high schools attended sums to 30 (not 26), and this is because several students attended more than one high school.

Despite the fact that 12 (46.2%) of these students reported having been hospitalized for their psychiatric disorders at least once in secondary school, and 22 (84.6%) reported having taken psychiatric medication while in high school, only three students were identified as having a disability and offered Special Education services (such as an IEP) available through the Individuals with Disabilities Education Act. It may seem surprising that more of these students did not receive IEPs in their schools to ensure equal access to a fair and appropriate education. However, later we will see that, on average, the students were reluctant to disclose their mental health struggles to adults in high school. As other studies have suggested, youth with emotional and behavioral

disorders are much more likely to disclose to their peers – if at all – than to teachers or counselors at school (Hickey et al., 2007; Hodges et al., 2007, Reavley, Yap, Wright, & Jorm, 2011; Rickwood et al., 2008). This, coupled with the "invisible" nature of many psychiatric disabilities, suggests that far more youth "fly under the radar" and are in need of mental health and educational supports in high school than are currently receiving them.

Table 4.1
*All Interview Participants - Demographics Overview*

| | n | % (n=26) | mean |
|---|---|---|---|
| Age | | | |
| all intv participants are age 18-25 | 26 | 100 | 20.4 yrs |
| Sex | | | |
| Female | 22 | 84.6 | |
| Race | | | |
| Caucasian | 16 | 61.5 | |
| African-American or Black | 4 | 15.4 | |
| Latino/a or Hispanic | 2 | 7.7 | |
| Multi-racial | 3 | 11.5 | |
| Other | 1 | 3.8 | |
| Completed online survey | 22 | 84.6 | |
| Completed two interviews *and* online survey | 20 | 76.9 | |
| General type of Psychiatric Disabilities[1] | | | |
| Mood disorder | 21 | 80.8 | |
| Anxiety disorder | 14 | 53.8 | |
| Psychotic disorder | 2 | 7.7 | |
| Eating Disorder | 3 | 11.5 | |
| Other[2] | 6 | 23.1 | |
| Two or more diagnoses | 14 | 53.8 | |
| Type of High School attended[3] | | | |
| Public | 18 | 69.2 | |
| Private | 9 | 34.6 | |
| Therapeutic | 1 | 3.8 | |
| Religious | 1 | 3.8 | |
| Other | 1 | 3.8 | |
| Was identified with disability & had IEP in HS | 3 | 11.5 | |
| High School cumulative GPA (4-point scale)[4] | | | 3.46 |
| Type of college currently attending[5] | | | |
| Attending 4-yr college | 23 | 88.5 | |
| Attending 2-yr college | 3 | 11.5 | |
| Private research univ[6a] | 12 | 46.2 | |
| Public research univ | 6 | 23.1 | |
| Private Liberal Arts college[6b] | 3 | 11.5 | |
| Public regional univ | 1 | 3.8 | |
| Public Community college | 4 | 15.4 | |
| Year in College[7] | | | |
| 1st yr of a 2-yr program | 4 | 15.4 | |
| 1st yr of a 4-yr program | 9 | 34.6 | |
| 2nd yr of a 4-yr program | 5 | 19.2 | |
| 3rd yr of a 4-yr program | 5 | 19.2 | |
| 4th yr of a 4-yr program | 1 | 3.8 | |
| 5th yr of a 4-yr program | 2 | 7.7 | |
| College cumulative GPA (4-point scale) | | | 3.39 |

N = 26

[1] Diagnosis percentages sum to over 100%; indicates high rate of comorbidity. Twelve respondents (46.2%) have 1 diagnosis, while seven (26.9%) have 2, and an additional seven (26.9%) have 3 or more.

[2] "Other" MH conditions: Self-harm (3), ADHD (1); Borderline Personality Disorder (1); and Conversion disorder (1).

[3] Number of high schools totals 30 because several students attended more than one school

[4] Twelve (46.2%) of the 26 interviewees had cumulative high school GPAs of $\geq$ 4.0

[5] Participants have attended a total of 21 different higher ed. institutions across 10 states; 18 students (69.2%) have attended only 1 school, while 9 (34.6%) have attended $\geq$2 separate colleges. Note that national rate for college transfer is 37.2%. (Nat'l Student Clearinghouse Research Center, 2015.)

[6 a,b] Seven of the 15 interviewees attending private institutions go to "most selective" schools (admit $\leq$15% of applicants)

[7] All interview participants are attending college full-time

Across the interviewees, fourteen different colleges and universities are represented: three public 2-year colleges, three public 4-year universities, five private 4-year universities and three private liberal arts colleges. It should be noted that three of the five private 4-year universities represented are "most selective" when compared to all other institutions of higher education across the country, meaning that they accept the smallest number of applicants (≤15%) and are largely regarded as "elite" universities. In addition, two of the three liberal arts colleges represented are "most selective," with both of them included in the top dozen colleges listed in *U.S. News and World Report's* 2017 compilation of the most selective colleges in the nation (see http://colleges.usnews.rankingsandreviews.com/best-colleges/rankings/national-liberal-arts-colleges). Given the high mean grade point average for this sample (3.46 on a 4-point scale in high school) and the high selectivity of approximately one third of the colleges and universities attended, we must acknowledge that this particular sample of students with psychiatric disabilities is not generalizable to all students with serious mental health challenges. Indeed, simply by virtue of the fact that they have all graduated from high school and matriculated into college, they are significantly different from the majority of their peers living with mood, anxiety, and psychotic disorders. They are, by and large, "high achievers" when it comes to academics. (For example, there are three high school class valedictorians included in this sample, making up 11.5% of the 26 interviewees.) It may be that students who are "exceptional" in terms of being able to manage their mental health challenges while excelling in school were more likely to volunteer to participate in this study than were students who were not doing as well academically.

In addition to type of high school and college attended, there is diversity in terms of how far along the participants are in their degree programs. At the time of their first interview, four participants were in the first semester of a 2-year Associates degree program, nine were in the first semester of their Freshman year in 4-year Bachelors degree programs, five were Sophomores attending 4-year schools, an additional five were Juniors, one was a Senior enrolled in a 4-year program, and two were fifth-year students enrolled in what are generally four year programs.

The first interview with every participant was conducted in-person, with the exception of three participants who resided more than one thousand miles away, precluding car or train travel to meet with them. I met with the remaining twenty-three interviewees on or near their college campuses at a location of their choice. Most students requested meeting in a quiet, private room in their campus libraries, while two invited me into their residence halls, and one met with me in her parents' home, where she currently lives.

Each wave one interview lasted between 60 and 120 minutes, with approximately 90 minutes as the modal time. All interviews were audiotaped and then subsequently transcribed by a professional transcription service. After that, I re-read each transcript and checked it for accuracy against the original recorded audio, making any necessary revisions or corrections. I then asked each interviewee via email if he or she would like to read or review this transcript, encouraging any additional corrections, revisions, or expansions from the participants. Ten students reviewed their preliminary interview transcripts, and none made changes, save for correcting several minor typos.

During the process of interviewing the 26 participants in the qualitative strand of this study, I began preliminary data analysis. This allowed me to utilize emerging issues and themes from the preliminary interviews to (1) inform subsequent interviewee selection, (2) inform the content and items included in the survey for the quantitative arm of the study, and (3) develop an interview protocol for the second interview. Twenty-two participants completed a second interview in Summer or Fall of 2015, nine to twelve months after their preliminary interviews. Four of the original participants decided to forego a second interview.

**Qualitative data analysis plan**

The data analysis plan for the qualitative strand of this mixed methods study is informed, but not limited, by classical grounded theory (Glaser & Strauss, 1967; Strauss & Corbin, 1990). Grounded theory is a research method that requires ongoing interplay between data collection and data analysis in order to produce a theory about a particular process or phenomenon that is based on inductive codes and themes and their interconnections (Strauss & Corbin, 1990). Inductive analysis "involves discovering patterns, themes, and categories in one's data. Findings emerge out of the data, through the analysts' interactions with the data" (Patton, 2015, p. 542). Drawing from this approach, I employ a constructivist paradigm in the qualitative strand of this study, with my interpretations of participants' mental health and educational trajectories providing building blocks for code, theme, and – ultimately - theory construction.

**Code Development.** The qualitative data are based on verbatim transcripts of each interview, and I began the analysis by reading the first three transcripts and reviewing them line-by-line. I applied open codes (Strauss & Corbin, 1990) to each

individual idea, concept, action, or event related to my original research questions. A code, in this context, functions as "a way of patterning, classifying, and later reorganizing each datum into emergent categories for further analysis" (Saldana, 2011, p. 91). My codes were developed employing constant comparison (Glaser & Strauss, 1967) at every level of the analytic process, meaning that I compared data within individual interviews, as well as across participants' interviews over time. As Charmaz (2006) explains,

> From the start, careful word-by word, line-by-line, and incident-by-incident coding moves you toward fulfilling two criteria for completing a grounded theory analysis: fit and relevance. Your study fits the empirical world when you have constructed codes and developed them into categories that crystalize participants' experience. It has relevance when you offer an incisive analytic framework that interprets what is happening and makes relationships between implicit processes and structures visible (p. 54).

My coding process began by identifying "open" codes; these were largely in vivo codes (Strauss, 1987), where I used participants' actual words to identify and label meaningful concepts. Each data segment (phrase, sentence, and/or paragraph) for every interview was coded with as many open codes as needed to describe and capture the content. My goal was to review all of the interview data for similarities and differences both within and among participants, and to ultimately understand the process(es) of college preparation and transition as reflected in the data. Each code was constantly compared to all other codes to identify similarities, differences, and general patterns (Bowen, 2006, p. 5).

Code book development entailed open-coding the first three transcripts, developing a preliminary manual of codes from these, and then utilizing this initial code book to code the remaining interviews as they were conducted and transcribed. Whenever a new issue or construct emerged that was not captured by an existing code, I

created a new code, label, and definition and included this new code in the codebook moving forward. I also reviewed all of the transcripts that I had already coded to see if new codes could be applied to earlier data.

**Construction of Focused Codes and Emergence of Inductive Themes.** The open codes were eventually "grounded" into more abstract categories, that I call "focused codes." These focused codes, or combinations of similar open codes merged into higher level codes, primarily occurred in phase 3 of the study (described below), during and after the second wave of qualitative data collection. After all of the interviews were re-coded with "focused codes," I reviewed the data comprehensively and began to cluster related focused codes into even higher level over-arching "themes." The themes were derived in much the same way that Bowen describes (2006):

> Themes gradually emerged as a result of the combined process of my becoming intimate with the data, making logical associations with the interview questions, and considering what was learned during the initial review of the literature. At successive stages, themes moved from a low level of abstraction to become major, overarching themes rooted in the concrete evidence provided by the data. When 'theoretical saturation' occurred – that is, when additional data failed to uncover any new ideas about the developing theory – the coding process ended. (p. 5)

In addition, Morse and Field (1995) provide a clear and concise description of thematic analysis that is relevant to my process, as well. Although thematic analysis is not exactly the same as grounded theory, the following description is useful in understanding my process:

> Thematic analysis involves the search for an identification of common threads that extend throughout an entire interview or set of interviews. Themes are usually quite abstract and therefore difficult to identify. Often the theme does not immediately 'jump out' of the interview but may be more apparent if the researcher steps back and considers, 'What are these folks trying to tell me?' The theme may be beneath the surface of the interview but, once identified, appears obvious. Frequently these themes are concepts *indicated* by the data rather than

> concrete entities directly described by the participants…Once identified, the themes appear to be significant concepts that link substantial portions of the interview together. (Morse & Field, 1995, pp. 139-130, emphasis in original).

Where I diverge from the classical grounded theory is in my explicit combination of inductive themes derived directly from the data and deductive themes culled from the literature. Disclosure, identity, recovery, and integration are constructs identified during my literature review (and presented Chapter Two, pages 37 through 50). I believe that exploring emergent themes in tandem with existing theories related to these constructs allowed me, as Ezzy (2002) writes, to arrive at "a new and more sophisticated understanding of (an) experience" (p. 94).

I also diverge from classic grounded theory in the names and number of stages that I employ in coding. While Glaser and Strauss (1967) originally prescribed three levels of coding in grounded theory (open, axial, and selective), I use these as a starting point and look to Auerbach and Silverstein (2003) and Charmaz (2006), as well. I combined elements from these three approaches to grounded theory, and arrived at the following adapted coding sequence: *open* coding → *focused* coding → identification of over-arching *themes* → integration of themes into *key theoretical constructs* → emergence of a *core code* that best captures the key constructs, themes, and codes, and can be expressed in a theoretical narrative.

Here, coding in general is a method to organize data and discover patterns and structure within them, moving from more concrete descriptions of content to more abstract and theoretical understandings of their implicit meanings and interconnections. *Open coding* here is "the process of breaking down, examining, comparing, conceptualizing, and categorizing data" (Strauss & Corbin, 1990); *focused coding* is a

step beyond open coding, where I began to link related codes into categories and higher level codes; next I constructed 11 major inductive *themes* that included all of the focused codes, and further categorized and abstracted these (this level is akin to Glaser & Strauss' "axial coding"); next I compared each of the 11 inductive themes with the four deductive themes, exploring how the concepts interact in participants' daily lives; afterwards, three *key theoretical constructs* emerged that capture all of the codes and themes and describe them in linked processes (further described in Chapter 5, Qualitative Findings).

The last stage of the qualitative analysis entailed selecting a *core code* that relates to as many of the other codes and themes as possible and validates those relationships (Strauss and Corbin, 1990, p. 116). The core code, *Education for Rehabilitation* (described in detail in Chapter 5) is the code that accounts for most of the data and around which the most data are organized. The final step in analysis compares this core code with existing theory to compose a "theoretical narrative" that presents what I learned about my research concern (Auerbach & Silverstein, 2003, p. 40). This narrative "tells the story of the participants' subjective experience, using their own words as much as possible" (Auerbach & Silverstein, 2003, p. 40).

A visual model of my general process of code, theme, and theory construction is presented in Figure 4.2, below, and a more specific example, with actual codes, is presented in Figure 4.3. (Note that themes and their definitions, as well as the focused codes comprising each theme, are presented in Chapter Five in Tables 5.1.1, 5.1.2, 5.1.3, and 5.1.4.)

**Figure 4.2** General model of theory construction for qualitative strand of study

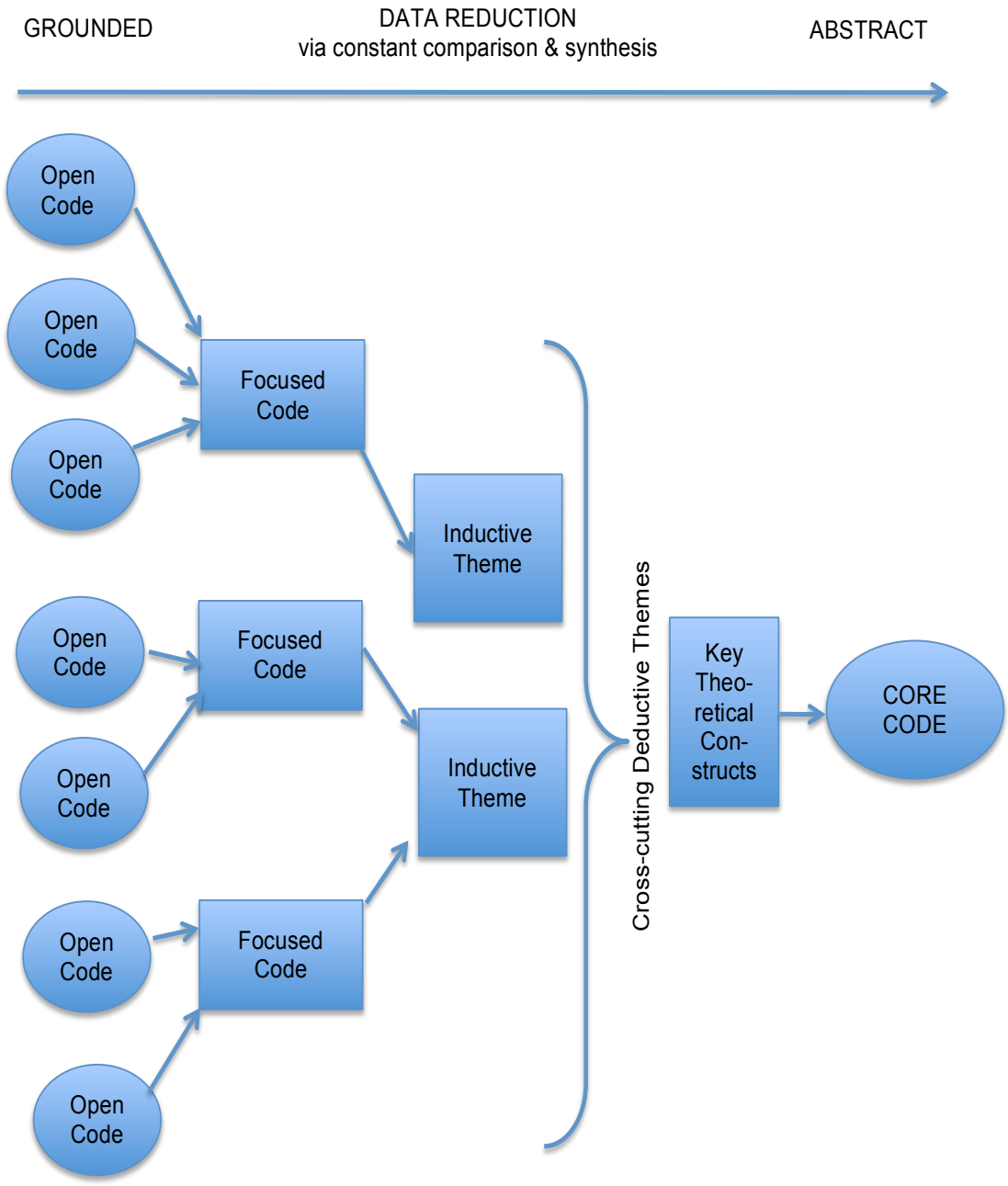
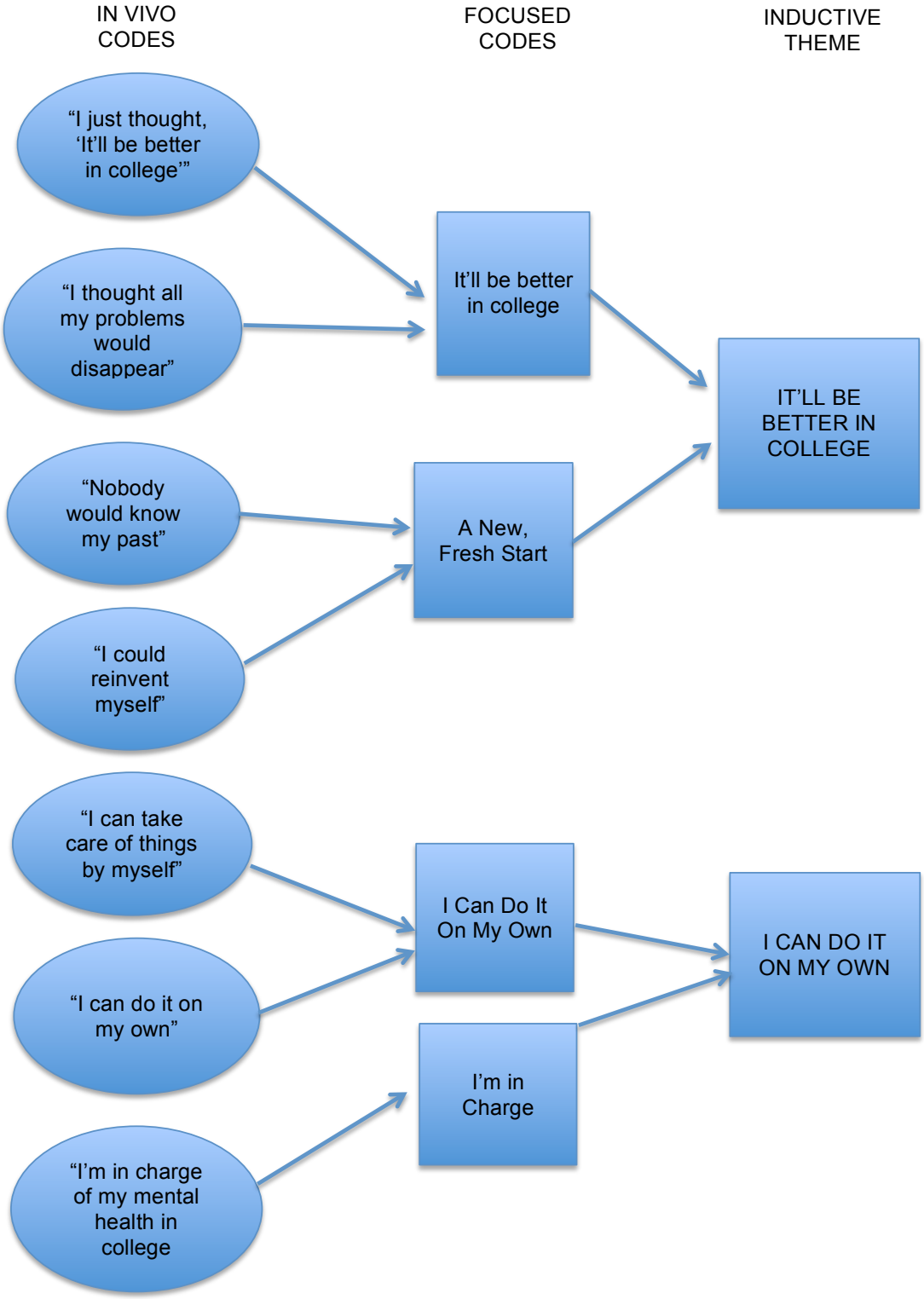


**Figure 4.3** Specific example of code to theme process of data reduction



**Establishing credibility and "trustworthiness" in qualitative research**

While rigorous quantitative research must meet benchmarks for reliability and validity, in qualitative research we must establish the "trustworthiness" of our data and findings (Lincoln & Guba, 1985). This can be accomplished through various means, and the current study employed triangulation, reflexivity, memo writing, member checking, and peer review.

**Triangulation.** In triangulation, data is obtained from multiple sources and in multiple ways. This was done in the current study by collecting both qualitative and quantitative data, and also by collecting qualitative data from participants at two points in time over the course of a year.

**Reflexivity.** Reflexivity refers to a researcher's candor regarding how his or her personal background, experiences, assumptions, and worldview shape the research process, particularly data collection and analysis (Kisely & Kendall, 2011, p. 365). I dedicate a section of Chapter One (pages 7-13) to my goals as a researcher, my position in relation to the study participants, and my own history of mental illness and recovery. I attempt to be clear and explicit about the experiences and assumptions that I bring to this work.

**Memo writing.** Memos are informal analytic notes made throughout data analysis in a grounded theory study (Charmaz, 2006, p. 72). Researchers "start by writing about codes and data and move upward to theoretical categories," fine-tuning their thinking as they move along (Charmaz, 2006, p. 72). Indeed, writing memos expedites analysis by providing "a space to become actively engaged in materials, to develop ideas, and to fine-tune (one's) subsequent data-gathering" (Charmaz, 2006, p. 72). Throughout analysis, I

wrote memos both in Word documents that I archived and reviewed on a regular basis, as well as directly in Atlas.ti, the qualitative data analysis software that I employed. I wrote at least one memo during or after each coding session, and I returned to these and developed many of them further over many months. Some memos evolved into codes, themes, or constructs, while others captured ideas and/or literature to explore further. This process of thinking through writing was invaluable, and much of what I wrote in "memo" form has grown into sections of this dissertation.

**Member checking.** I believe that the adequacy of research can be evaluated by how relevant and useful the findings are for the participants and others like them. That said, I employed "member checking" (Creswell, 2014, p. 201) during the analysis of the qualitative data. Well into the data analysis stage, I asked three study participants to review the 11 inductive codes that I constructed, as well as the 3 key theoretical constructs and related work-in-progress definitions. After sending the three participants a written synopsis of the emerging themes and constructs and their meanings, I reviewed these with each of them over the phone. The participants each said that they personally identified with many of the themes, and that they could also see how the three theoretical constructs applied to their lives. At the end of these conversations, I asked the participants about what I believed was emerging as the core code, *Education for Rehabilitation*; when I explained what I meant by this – the elements and processes inherent in successfully transitioning to and through college for emerging adults with psychiatric disabilities – they said that the concept resonated with them.

**Peer review.** I also shared select interview excerpts that I had coded with three colleagues and asked for their feedback mid-way through my analytic process. I chose

this time-point intentionally to ensure that what I was seeing in the data, and how I was making sense of it, also made sense to other scholars in related fields. In addition to assuring me that my themes were developing in a way that was logical and also supported by data, my three colleagues also offered insights about what they, themselves, saw in the data, what additional questions they might ask interview participants at Time 2, and how they thought findings could be applied in school and university settings. In all, it was a privilege to have peers share their time, expertise, and ideas to make this study more valid, and, hopefully, more valuable, as well.

**Quantitative Strand**

I utilized preliminary findings and emerging themes from the first wave of qualitative data, as well as constructs from the literature, to inform development of the online survey. As this study was designed with an exploratory sequential mixed methods approach in mind, the goal from the outset was to utilize the qualitative data to develop the survey and boost its validity. I also wanted to recruit a larger sample than just the 26 interview participants to see if some of the collective and recurring experiences that students described in interviews were, in fact, prevalent in a larger sample of students. And, finally, after having worked through some hypothesis-generation and theory-development, I wanted to test the hypotheses that mental health disclosure is related to both institutional integration and recovery.

**Survey development.** I was able to translate many of the topics that I explored with participants in interviews into sections, and/or items, for the survey. The completed survey includes the following ten sections: demographic questions; respondents' high school experiences related to having a psychiatric disability; choices surrounding

disclosure of disability status at school; activities related to college planning, selection, and application; college experiences related to having a psychiatric disability (including decisions about whether to use on-campus Student Disability Office services and/or Counseling and Psychological Services); a new pilot measure of "mental illness disclosure" that I created based on many of the disclosure issues that emerged in the interviews; and existing, validated measures to assess the subjective experience of institutional integration and recovery (described below), which were also issues that permeated nearly all of the interviews. To review the completed online survey, please see Appendix K.

**Validated existing measures.**

***RAS***. The Recovery Assessment scale (RAS) is a measure of recovery as a process (Corrigan, Giffort, Rashid, Leary, & Okeke, 1999). The instrument assesses the following five factors:

- Personal confidence and hope
- Willingness to ask for help
- Goal and success orientation
- Reliance on others
- Not dominated by symptoms

The original RAS has 41 items, but the revised (shorter) RAS used in this study is a 24-item scale in which respondents describe themselves using a 5-point Likert scale on which 5 is "Strongly Agree" and 1 is "Strongly disagree." Sample items include: "I have a desire to succeed" and "I can handle it if I get sick again." Research on the scale has shown satisfactory reliability and validity, with a Pearson Product Moment Correlation of

r = 0.88, and a Cronbach's alpha = 0.93, showing good internal consistency (Corrigan et al., 1999, p. 234). Exploratory and subsequent confirmatory factor analyses yielded the 5 cross-validated factors, above, that parallel the theory of recovery as a process (Corrigan et al. 2004). The possible high total score for the RAS is 120 points.

***IIS.*** The Institutional Integration Scale is a 34-item instrument originally developed by Pascarella and Terenzini (1980) to predict persistence among college Freshman, as well as "voluntary dropout decisions." The instrument is based on Tinto's explanatory, predictive model of "dropout process" (1975), which is built on the core concepts of academic and social integration in an institution of higher education. Tinto's model is longitudinal and regards persistence or dropout behavior primarily as "a function of the quality of a student's interactions with the academic and social systems of the college" (Pascarella & Terezini, 1980, p. 60).

French and Oakes (2004) adapted Pascarella and Terenzini's original measure and found improved psychometric properties (French & Oakes, 2004). They write that "the revised scale scores have satisfactory internal consistency, reliability and inter-correlations among the subscales and with the total scale" (p. 88), and the Cronbach's alpha =.92. Their revised instrument takes approximately 10 minutes to complete, and it contains 34 items that comprise the following five subscales:

- Peer Group Interactions
- Interactions with Faculty
- Faculty Concern for Student Development and Teaching
- Academic and Intellectual Development
- and Institutional and Goal Commitment

The choice to include the RAS and IIS was done after reviewing various similar instruments. I ultimately selected the IIS and RAS because these two measures have been tested, are valid and reliable, and they measure key constructs related to the experience of students with psychiatric disabilities that I was interested in investigating.

**New measure of "disclosure."** I created a new pilot instrument to measure level and types of mental health disclosures to classmates and school faculty/staff. After interviewing the intial 26 study participants in the first wave of qualitative data collection, I paid close attention to what they said regarding the recipients of their disclosures in school settings, their reasons for disclosing, and their perceptions of recipients' reactions to disclosures. Analysis of the interview transcripts yielded 40 items representing the construct (and related processes) of mental health disclosure for these students in school. After developing these items, I shared them with an independent group of 4 emerging adults with mental illness, who reviewed them for credibility and transferability. Based on their feedback, I added several more items (e.g. reasons *not* to disclose, as well as items related to disclosing in college application essays), and the result is the current 92-item measure. (Note that this measure consists of 46 paired questions – 1 each for high school and college disclosures, and paired to assess change over time).

Respondents chose the most appropriate response from a 5-point Likert scale (where 5 was "Strongly Agree" and 1 was "Strongly Disagree") when given certain prompts. Sample prompts are: (a) "I disclosed some of my mental illness experience to certain close friends in high school in order to share details about my life and deepen

friendships," and (b) "I disclosed some of my mental illness experience to faculty or other staff at my college so they could understand me better."

This dissertation serves as a pilot of the disclosure measure. I have not yet tested the psychometrics of the measure, but will do that as a next step in this research trajectory.

**Survey sampling, recruitment, and implementation.** For the quantitative strand of the study, a total of 78 current college students ages 18-25 with self-reported mood, anxiety, or psychotic disorders from across the U.S. completed an anonymous online survey. Participants were recruited via social networking sites related to youth mental health as well as websites for national mental health organizations. (See Appendix C for a list of recruitment sites' URLs and twitter handles, and see Appendix I for the IRB-approved text used for survey recruitment via social media.) The survey was created in Qualtrics and available online through the Penn GSE website from September 2015 through February 2016. People meeting the inclusion criteria were directed to the survey page and asked to first consent, and then complete the survey.

Given estimates that there were approximately 12 million U.S. college students under age 25 in 2014 (NCES, 2016), the year that study participants were recruited, and between 10% and 32% of college students has a serious mental health condition (Eisenberg, Hunt, & Speer 2013; Ellison, Rogers, & Costa, 2013; Mowbray et al., 2006; Sharpe, Buininks, Blacklock, Benson & Johnson, 2004), I estimated that 3 million college students (approximately 25% of all college students between the ages of 18 and 25) met DSM-V critieria for a diagnosable mental health condition that year. With this

estimate, I projected an optimal sample size for the quantitative strand of this study using an online sample size calculator found here: http://www.surveysystem.com/sscalc.htm).

Sample size calculator results show that in order for my survey findings to be generalizable to the broader population of college students with psychiatric disabilities, with a confidence level of 95% and a confidence interval of $\pm$ 5, I would need 384 survey respondents. Because I was only able to recruit 78 survey respondents, with a confidence level of 95% I have a confidence interval of $\pm$11. That said, if I estimate that 50% of my sample selects a particular response on the survey, I can only be "sure" that if I had asked the same question of the entire relevant population, between 39% (50 -11) and 61% (50 + 11) would have selected that same response. Because this confidence interval is so large, I cannot generalize findings from this sample of 78 to the larger population of college students with psychiatric disabilities. I can, however, look for trends in answers within the sample, and then utilize these findings in a later and similar survey with a larger sample size.

**Reliability and validity in quantitative research.** Here I take a moment to address three types of validity (content validity, construct validity, and external validity) that I employed to boost the credibility of the survey.

Content validity has to do with whether survey items are relevant and a logical way to gather the data necessary to answer one's research questions (Haynes, Richard, & Kubany, 1995). I provide the survey in its entirety in Appendix K and invite readers to review it in the context of my research questions. Namely, does it seem likely that answers to its questions would allow me to explore transitions to and through college, mental health disclosures in educational contexts, and relationships among disclosure,

institutional integration, and recovery? I am confident that the survey items are valid in that they were thoughtfully developed after a literature review and conducting 26 in-depth interviews.

Construct validity is an over-arching term to assess whether operational variables adequately represent theoretical constructs (Steckler & McLeroy, 2008). Put simply, construct validity relates to a survey's capacity to measure what it claims to measure. Here, I refer readers to the section, above, where I describe the psychometric properties of the IIS and RAS. In addition, although I have not yet tested the psychometric properties of the new disclosure measure piloted in this study, my approach to measuring "disclosure" is informed by the 26 interviews that I did prior to developing the survey, as well as by my literature review and close readings of Tinto (1975), Pascarella and Terezini (1980), and multiple articles on the process of recovery from mental illness (see Anthony et al., 2002; Corrigan et al., 1999; Corrigan & Phelan, 2004; Davidson & Roe, 2007; Deegan, 1988 and 1996).

External validity refers to the extent to which causal relationships can be generalized to different measures, people, and contexts (Steckler & McLeroy, 2008). I realize that my survey sample is not necessarily generalizable to the larger population of emerging adult college students with psychiatric disabilities; this is primarily due to the fact that I recruited through campus-based mental health organizations that likely attract members who are potentially more "integrated" into their communities, less isolated, and higher functioning than peers who are not members of such groups. However, while I acknowledge this limitation, I am proud of the fact that 78 young adults completed this study's *very* long survey. This sample size allows for inferential statistics (see Chapter

Six, Quantitative Results), and it also boosts the survey's validity. Although findings are not necessarily generalizable to all college students ages 18-25 with mental illness, it is likely that many such students *would* respond to this survey similarly. That said, I propose that the survey results are "transferable" in the way that Lincoln and Guba described (1985) when writing about qualitative findings. After reviewing the survey (Appendix K) and the findings, readers can assess how transferable these findings are to themselves (if they are students), or to young adult students with whom they work (if they are educators, university administrators, or mental health professionals).

**Quantitative data analysis plan.** I used the SPSS software package to facilitate the statistical analysis of the survey data. In Chapter 6 (Quantitative Results), I present descriptive statistics (means and standard deviations etc.), as well as correlations among variables. I also present paired samples *t*-Test results to assess whether there are mean differences between High School and College for various (paired) survey items (E.g. "I am satisfied with my social life in high school/college" or "I disclosed to certain faculty and staff at my high school/college.") And, finally, I employ linear regression to investigate whether measures of Disclosure can predict IIS, RAS, and their sub-scales.

**Second Qualitative Strand of Study**

**Interview time 2 sample.** I completed Time 2 interviews with the initial 22 participants. These 22 also completed the online survey so that (1) I could increase the survey sample size, and (2) I can (in future work) track the interview participants changes in disclosure type, level, and recipient(s) over time, linking these experiences with their interview data.

**Creation of second interview protocol, individualized for each participant.** There were several questions that I asked all of the T2 interview participants (e.g. "How have you been since we last spoke," and "What does 'recovery' mean to you"), but I also individualized each T2 discussion guide based on what I had gleaned from the participant's first interview, with particular attention paid to any goals or aspirations mentioned in the T1 interview that may have panned out by T2 data collection (e.g. achieving a particular GPA, exploring available services at the campus Student Disability Services office, or acquiring a part-time job). For an example of this type of individualized T2 interview discussion guide, please see Appendix G.

**Analysis of Time 2 qualitative data.** Just as was done after the first round of interviews, the second interviews were recorded, transcribed verbatim, and then coded with the code book that had already been created by the end of the first round of interviews. If new topics emerged in the second round of interviews that warranted new open codes, new codes were added to the code book and earlier interviews were reviewed and recoded if necessary.

I was particularly interested in the changes that had occurred in the students' lives between their first interviews (fall of 2014), and their second interviews (Late Summer or Fall of 2015). Two interviews with each participant allowed for exploration of changes in their experience over time, as well as their own perceptions, reflections, and meaning-making related to these experiences. In addition, conducting more than one interview with each student made it possible to revise the subsequent interview guide by incorporating earlier ideas or unanswered questions into it. Interviews at Time 1 primarily explored the strengths, skills, and strategies that students employed to navigate

high school and graduate while also managing their diagnoses; their expectations for higher education and related college planning activities; and their experiences in college to date (including social and academic integration, mental health disclosures, and use of Student Disability Services and/or Counseling services on campus). Special attention was paid to factors influencing decisions related to disclosure of psychiatric disability status in educational contexts. Interviews at Time 2 explored any new developments in the student's educational path since the first interview, follow-up to particular issues raised in the first interview, and also a question about the students' understanding of the term "recovery."

Each interview participant, then, has a pair of interviews that were individually coded, and then compared with each other (across time) before then comparing these with the rest of the participants' interview data. I continued the process of constant comparison that I initiated in phase 1 of the study, and I also progressed past "open coding" to develop higher level "focused codes" and – ultimately – over-arching "themes" during and after the second round of qualitative data collection. (Open codes, focused codes, themes and constructs are described in detail in Chapter 5.)

**Procedure to Merge and Compare Qualitative and Quantitative Databases.** The two databases for this study, qualitative and quantitative, will be merged in a theme and statistics "merged data analysis display" (Creswell and Plano Clark, 2011, p. 226) in Chapter Seven. This will take the form of a summary table merging the 11 inductive themes that emerged from the qualitative strand of the study with related quantitative findings from the survey.

## Chapter Four Summary

This chapter opened with the research questions for the study as well as a visual representation (Figures 4.1.1 and 4.1.2) of the over-all study design. Next, I described the initial wave of qualitative data collection and the preliminary analysis of those data. Following that, I provided details on the development and implementation of the online survey, as well as a discussion of validity related to this survey. Next, I described the second wave of qualitative data collection and analysis, and ended the chapter with a brief description of the joint display technique that I will employ in Chapter Seven to integrate and merge the qualitative and quantitative databases.

# CHAPTER 5

# QUALITATIVE FINDINGS

## Chapter Overview

This chapter begins with presentation of the eleven *inductive themes* and related *focused codes* that emerged from the qualitative data. Tables 5.1.1, 5.1.2, 5.1.3, and 5.1.4 present focused codes, themes, and example quotes for each in an abbreviated format. After introducing the themes in the form of these tables, I then go more in-depth, defining and describing each one with further examples from the data. (Note that focused codes are *italicized*, and themes are in CAPITAL letters, below.) And, adding to the literature review in Chapter Three, here I incorporate select literature relevant to various themes as they are presented.

After the above sections, I introduce four deductive themes (disclosure, identity, recovery, and institutional integration) that cut across all of the inductive themes. I then share the three *key theoretical constructs* that emerged from careful analysis of the interactions of the inductive and deductive themes: (1) *Strategically Disclosing Aspects of Mental Health*; (2) *Constructing a Recovery Identity*; and (3) *Experiencing Academic and Social Integration on Campus.* After describing and defining these key constructs, I propose a core code, *Education for Rehabilitation,* explaining how this code ties together the preceding concepts.

**Table 5.1.1**: Grounded themes, codes, and examples, Themes 1-3

| Theme and Definition | Focused Codes Comprising Theme | Example Quotes to Illustrate Codes |
|---|---|---|
| (1) SECRETS & SILENCES<br><br>Describes hiding or masking one's mental illness or symptoms; keeping it "secret" in school settings.<br><br>The theme also includes descriptions of being "found out," or of feeling forced to disclose in educational contexts. | *Always a Big Secret*<br><br>*Putting On a Good Face*<br><br>*Forced Disclosure* | "In high school it was always a big secret. I hid it from everyone.""<br><br>"I'd put on a good face at school, and then go home and relax back into my depression."<br><br>"Sometimes people already know. Like when my OCD got really bad at school and it affected my speech, even, it was pretty obvious that something was going on with me." |
| (2) IT'LL BE BETTER IN COLLEGE<br><br>Students' expectations (in HS and during initial transition to higher education) that their mental health, social lives, and quality of life will improve in college.<br><br>The theme highlights hope and optimism, as many participants reported believing that college would afford a "new, fresh start" and opportunities to "re-invent" themselves . | *It'll Be Better in College*<br><br>*A New, Fresh Start*<br><br>*Reinvention & Identity Management* | "I just thought, 'it'll be better in college.'"<br><br>"I really believed that with a new, fresh start, all my problems would go away."<br><br>"Nobody would know my past. I could re-invent myself." |
| (3) I CAN DO IT ON MY OWN<br><br>Expressions of self-determination and/or self-reliance.<br><br>Many of the study participants express a desire for independence and autonomy (typical in young adulthood), but this leads some of them to rebuke available supports perceived as "special treatment." | *I Can Do It On My Own*<br><br>*I'm In Charge*<br><br>*Testing Possibilities*<br><br>*[No Special Treatment]* | "I can take care of things by myself – I'm used to that."<br><br>"I want to be in charge of my mental health in college."<br><br>"I moved far away to challenge myself."<br><br>[*See DISABILITY? *ME*?! below] |

Note: Codes that are related to more than one Theme are designated with [ ]

**Table 5.1.2**: Grounded themes, codes, and examples, Themes 4-5

| Theme and Definition | Focused Codes Comprising Theme | Example Quotes to illustrate Code |
|---|---|---|
| (4) THERE'S SOMETHING YOU SHOULD KNOW<br><br>Mention of voluntary mental health disclosures in educational contexts: when, where, why, to whom, reasons for and against telling, and examples of actual disclosures and people's reactions to them | *[Friends can Help You]*<br><br>*Coming out 'Crazy' at School*<br><br>*Telling in College Essays*<br><br>*Strategic Disclosure*<br><br>*Reactions to Disclosures* | "I told my suitemates what to expect if I have a panic attack, so they won't freak out and they can help me."<br><br>"In my AP Psychology class we were talking about 'abnormal' psych and bipolar disorder…I just had to say something…"<br><br>"I wrote about it in my college essay. My mom didn't think that was a good idea, but it explains a lot."<br><br>"Sometimes when I'm getting close to someone, I'll just say, 'there's something you should know about me.'"<br><br>"The teachers I've told have been pretty understanding." |
| (5) DISABILITY? *ME*?!<br><br>Students' conceptions or descriptions of being "disabled" (or not), as well as feelings about "accommodations." The "?" in the theme label implies a skepticism regarding whether one is "disabled." This is related to whether and how campus Student Disability Services are seen as relevant, and/or whether MI is even a "real" disability. | *I Have a Disability?* Me*?!*<br><br>*[No Special Treatment]*<br><br>*Getting Away with Something*<br><br>*Are Those Services For Me?*<br><br>*Accommodating to Accommodations* | "I never really thought of it as a disability"<br><br>"I don't want special treatment from professors."<br><br>"I'm afraid that people might think I was getting away with something if I got extra time."<br><br>"I thought those were for people with physical disabilities or learning disabilities. I didn't know they applied to me.<br><br>"Maybe I *do* have a disability and accommodations could help a little." |

Note: Codes that are related to more than one Theme are designated with [ ]

**Table 5.1.3**: Grounded themes, codes, and examples, Themes 6-8

| Theme and Definition | Focused Codes Comprising Theme | Example Quotes to illustrate Code |
|---|---|---|
| (6) RELATING FOR RECOVERY<br><br>This theme includes mention, description, or examples of receiving and/or giving social support or engaging in relationships that benefit mental health, well-being, and over-all recovery.<br><br>Note that this includes codes related to study participants teaching or prepping friends and others to be better equipped to offer appropriate support if/when needed. | *Relational Recovery*<br><br>*Social Support – It Goes Both Ways*<br><br>*[Friends Can Help You]*<br><br>*[Relational Spaces]* | "Sometimes your friends are like medicine."<br><br>"It can go both ways. My friends help me a lot, but they also come to me for advice because they know I've been through a lot."<br><br>[*See THERE'S SOMETHING YOU SHOULD KNOW, above]<br><br>"My boyfriend has bipolar, too, and it's nice to have someone who gets it. I can always be honest around him and I don't have a lot of places to do that." |
| (7) SAFE SPACES<br><br>This theme explores the concept of having or desiring a "safe space" while a college student (both literally and figuratively") in which to live, learn, work on one's recovery, manage symptoms, disclose if desired, and connect w/ peers who have similar lived experiences. | *Physical Spaces*<br><br>*[Relational Spaces]* | "My room needs to be a safe space where I can go and just be with my moods, without having to explain myself."<br><br>"I need a single room because I do tele-psychiatry with my doctor back in California, and I don't want my roommate to hear me in therapy."<br><br>[*See RELATING FOR RECOVERY above] |
| (8) TIME OUT OF SCHOOL<br><br>This theme reflects both voluntary time away from school to focus on recovery, as well as unexpected or involuntary medical leaves. "Time away" could be short term (e.g. a result of side effects due to changing medication), or long term (e.g. a hospitalization or extended medical leave for intensive treatment over time).The code also includes descriptions of transferring among colleges, as well as experiences and challenges related to *returning* to school after an absence. Finally, the theme includes conceptions of "lost time" by participants, as well as related lessons learned. | *Missing Class*<br><br>*Hospitalizations & Medical Leaves*<br><br>*Transferring*<br><br>*Trying to Return*<br><br>*Lost Time* | "Sometimes I'll just take a mental health day. If I don't feel up to class, I just stay in bed."<br><br>"I think my time at home honestly made me more depressed….it was so isolating"<br><br>"I've gone to four different colleges, and finally landed at one that feels right"<br><br>"They made it so hard for me to come back…it left me with the impression that they didn't want me to come back at all"<br><br>"I didn't want to be behind all of my classmates because of my medical leave." |

Note: Codes that are related to more than one Theme are designated with [ ]

**Table 5.1.4**: Grounded themes, codes, and examples, Themes 9-11

| Theme and Definition | Focused Codes Comprising Theme | Example Quotes to illustrate Code |
|---|---|---|
| (9) FINDING PURPOSE<br><br>This theme captures descriptions of seeking and/or finding meaning in life. Includes mention of having a purpose, belief, goal, activity – or even a career plan - that is meaningful to oneself, but that also transcends the desire for simple personal gain | *Finding Purpose*<br><br>*Helping Others*<br><br>*[School As Motivator]*<br><br>*Mental Health Advocacy* | "I want to be a high school counselor so I can work with kids who have the same problems that I did."<br><br>[*See THE (PATIENT) STUDENT, below]<br><br>"I'm starting a chapter of Active Minds on my campus. Their slogan is 'changing campus conversations about mental health.' And we totally need that!" |
| (10) THE (PATIENT) STUDENT<br><br>This theme captures how study participants see themselves as students, as well as their aspirations to attend and complete college. The theme also includes mention of desire to stay in school and/or continue one's education despite mental health challenges.<br><br>And, finally, the theme addresses students' evolving academic identity, where "patient" refers not solely to a student's medical or mental health status, but also to the process of embracing a path through college that may take longer than four sequential years. | *Engaging in School*<br><br>*High Hopes for College*<br><br>*Being a Good Student*<br><br>*[School as motivator]*<br><br>*[Lost Time]* | "I really enjoy being in class"<br><br>"I always knew I'd go to college"<br><br>"I try to be a good student"<br><br>"Keeping on top of my health is important so I can stay in school."<br><br>[*See TIME OUT OF SCHOOL, above} |
| (11) LEARNING TO LIVE<br><br>Descriptions of practical strategies for simultaneously managing one's mental health and academic responsibilities in college. This code also includes recognizing that one's mental illness or related symptoms may not entirely go away, and that recovery is a process.<br><br>And, finally, the code includes acknowledging one's mental health challenges, but not being defined by them; learning to thrive in college. | *Striking a Healthy Balance*<br><br>*My Health or My Homework?*<br><br>*More Than My diagnosis*<br><br>*Learning to Live*<br><br>*Wherever You Go, There You Are* | "You have to strike a balance when it comes to socializing. I mean, I still go to parties, but I don't drink anymore. That did *not* work!"<br><br>"Some of my meds make me really tired, and if I have a lot of reading to do or I need to cram for a test, it's like, 'what's more important, my health or my homework?'"<br><br>"I'm more than my diagnosis. It's a part of me, sure, but it's definitely not all of me."<br><br>"I'm learning to live with this depression."<br><br>"You can't run from your problems. There's a point where you just have to face them." |

Note: Codes that are related to more than one Theme are designated with [ ]

**Description of Eleven Inductive Themes**

**SECRETS & SILENCES.** This theme describes hiding or masking one's mental illness or symptoms in educational settings: keeping one's psychiatric disability "secret" in school, and/or attempting to "act normal" and "be like everybody else." The theme also includes descriptions of being "found out," or of feeling forced to disclose some aspect of one's mental health history or status because questions arise, or, as one participant, Jake, explains, "it became so obvious that I could no longer hide it."

***Always a big secret.***

> "It was always a big secret in high school. I didn't tell *anyone*."
> – Max (18, a college Freshman)

Many of the interview participants describe keeping their mental health struggles to themselves in childhood and adolescence, even when symptoms were severe. Paige (21, a college Junior) describes having a sense that something was "wrong," or "different" about her at an early age, yet feeling reluctant to share these concerns:

> "I've always been moody. I've always had highs and lows. I just didn't realize that that's *not* how it's supposed to be. I think I just got used to it, to be honest. I remember when I was a kid - I would just wonder if it was okay to think about death and killing myself. I never admitted it, though. But when I was little I always used to think about that. It was weird. I don't think I actually wanted to, but I'd always think about how to do it…That was when I was seven - very young. I don't think that's normal - and I knew it wasn't normal to *ask* if it was normal. So I never talked about it at all."

Max adds that he feared relational repercussions, so "kept it hidden from all my friends," and that he, like Paige, was hesitant to even discuss his depressed mood with his closest relatives:

> "I just really didn't want people to know. I was afraid of what would happen if they did know, like maybe they'd just not want to be friends with me anymore.

> And I definitely didn't want my family to know, either. They always had a fear of depression because my cousin committed suicide before I was born….I managed to hide it [depression] from my family all the way up through twelfth grade. My mother actually did not know I was so depressed until she got a call when I was hospitalized here at X University."

Unlike Max, Bella (age 18, a college Freshman) was always able to talk to her parents about her depression and anxiety, but she chose not to broach the topic with her friends at school:

> "I've been hospitalized twice. When I came back [to school] the first time, I did not tell *anybody* where I'd been. I just told them I had the flu. I didn't tell them that I was really depressed or anything, just because I didn't feel like they needed to know. I just said I was sick. Which was true."

In contrast to Bella's strategic use of "illness" as a vague, yet valid, excuse for her absence from school, Ava (age 22, a college Junior), explains that she never equated her mood disorder with illness, and that she has consistently tried to keep it hidden even when it affects her academic progress.

> "Depression is really a *serious* impediment to getting your school work done. In high school – and even now – I never really hesitated to tell a teacher when I was sick. But it would never occur to me to say 'I've been feeling really depressed. I haven't been able to do my homework or finish that paper.' I think that there is a bit of shame that comes with admitting it to somebody."

***Putting On a Good Face.*** In order to keep their mental health "secret" in high school, many of the study participants worked to "keep up appearances." Max describes expending a great deal of energy to appear fine during the school day despite his major depression:

> "I was putting on a good face at school, and then I'd go home and kind of relax back into it [the depression]."

Samantha (age 19, a college Freshman) tells of keeping her mental illness private during high school not for fear of being found out, but because she desperately wanted to fit in

with her peers and "just be normal." Here, she describes her mindset returning to school after her first psychiatric hospitalization as a high school Sophomore:

> "I just *really* wanted to be normal. I wanted to experience normal high school things with my friends, you know? So I really tried more than I was able to, to fit into the high school environment. And I actually, because of pushing myself in that way, suffered from even *more* depression, I think. And I kind of spiraled down and down until I had to leave school again and go back to the hospital."

***Forced Disclosure.*** Jack (age 19, a college Sophomore), experienced *Forced Disclosure* when, in 8th grade, his severe OCD manifested in a way that made it obvious to peers and staff at his middle school that something was "totally off" with him.

> "I would talk in a really formal, precise way, and also very quickly. Not normal for a 13 year old. And if it didn't come out right, I would have to start all over and say what I was trying to say again. It got to the point where what I was saying sounded like gibberish, and I really couldn't communicate anymore. It was obvious that something was totally off with me."

After finally getting a correct diagnosis from a pediatric psychiatrist and undergoing intensive residential treatment to learn to manage his OCD, Jack was able to return to school. "A bunch of kids asked me where I was, and what was going on with me, and I just felt that I owed them an explanation." With lots of planning and some practice at home in front of his little sister, Jack stood up in an assembly and shared his diagnosis with his classmates, taking the time to answer any questions they had, and letting them know that he was still working on getting better every day. "They were really surprised that OCD isn't just washing your hands a hundred times in a row," he laughs. "I think I was able to teach them a lot - like the difference between obsessive thoughts and compulsive actions, and how hard it is just to get up and go to school some days." After realizing that his peers were curious about what had happened to him, and faced with questions upon his return, Jack turned his mental health crisis into an

opportunity to educate his peers. What was initially a *Forced Disclosure* ("they totally knew that something was up with me") became a *Strategic Disclosure*, and one that increased Jack's sense of self-efficacy and self-esteem.

Descriptions of reluctance to disclose elements of one's mental illness to peers, teachers, and even to parents in high school was a recurring theme when the interviewees reflected on their experiences in high school. Later, the majority of them arrived at a place in college where, instead of SECRETS AND SILENCES, they opted for *Strategic Disclosures* to trusted confidantes, as Jack had done much earlier. This move toward higher levels of disclosure in certain circumstances is explored in theme #4, THERE'S SOMETHING YOU SHOULD KNOW ABOUT ME, and its related focused codes, below.

**IT'LL BE BETTER IN COLLEGE**

"I just thought, 'it'll be better in college.' It had to be." - Max

This theme (also a focused code) captures students' expectations in secondary school and during the initial transition to higher education that their mental health, social lives, and over-all quality of life would improve in college. The theme highlights the hope and optimism typical in emerging adulthood (Arnett, 2004), with many of the interviewees reporting having had a strong belief that college would afford an opportunity to leave their pasts behind them and to reinvent themselves in a new context.

***A New, Fresh Start.*** Inherent in the optimism of IT'LL BE BETTER IN COLLEGE is a comparison with high school. Many of the interviewees described lackluster high school experiences, feelings of isolation, loneliness, few friends, and – for many – periods out of school due to symptoms or treatment. Max describes how his

idyllic vision of college life motivated him to "just make it through" high school: "The only thing that was keeping me going was thinking that if I got into a good college, the depression would all go away." Like many of his peers, Max assumed that once he entered college, his symptoms would abate. "I really believed that with a new, fresh start, all of my problems would go away," he says. Here, optimism and the concept of "a new fresh start" apply to students' assumptions that a new location and context (college) will "solve all [their] problems."

Like Max, Ava described high hopes that her mood would lift once in college, and that her reinvention of self would include a new and improved outlook.

> "I think in high school I was very convinced that because I had become depressed in high school, that it was my high school that was making me depressed…When I went to college I was incredibly happy. I met a lot of people. I met my boyfriend in the first few weeks. We had a solid group of fifteen, twenty friends who would hang out every weekend. That was unlike anything I'd ever had in high school. But you know, I got my taste of freedom and went a little wild. I was pretty involved in the party scene and didn't take care of myself at all. And that's a recipe for disaster if someone has a vulnerability for depression - even if they're in the perfect life that they've always wanted. It's just not sustainable."

When her depressive symptoms worsened, Ava had a realization:

> "Depression hit me really hard again at the end of my first semester here [a selective liberal arts college] – probably harder than it had in high school because I didn't have my family around to support me. I think it occurred to me then that it wasn't my high school after all – that it was *me.* And that was a really frightening thought."

Max had a similar revelation when his depression became worse in the first semester of his Freshman year:

> "I guess I always just equated college with happiness. I thought 'if I go there, I'll be really, really happy.' I thought it would be a great and wonderful place. And when I got here – don't get me wrong - it was everything I thought it would be, but that doesn't change how you feel on the inside."

Students expressed generally feeling full of hope and optimism about their educational futures, believing that "things will be better in college". This conception of "a new, fresh start" available in college, however, led some students to feel that continued mental health services and/or academic accommodations would be unnecessary in higher education. This, in turn, became a factor in certain students not considering their mental health diagnoses when planning for, applying to, and transitioning to college. In such cases it seems that a sense of optimism and self-efficacy can paradoxically create barriers to help-seeking and put certain students at heightened risk for exacerbation of symptoms and academic challenges when they do matriculate into higher education.

***Reinvention and Identity Management.*** Like many of his peers in this study, Adam (age 19, a college Freshman) was excited and enthusiastic regarding entering college. His optimism, however, was linked to viewing higher education as a context for reconstructing the self, embodied in the focused code *Reinvention and Identity Management*.

> "I had the mindset when I came here [to college] that I'm moving across the country, I have a Fresh Start with everything. Academically, I'm transitioning from high school to college. It's a clean slate. I'm starting from this point. Let's start it right. Same with friends, I was like, 'okay, I don't have to deal with anything from home. I don't have to explain myself or anything anymore.' People are meeting for the first time in their lives, and that means it's a clean slate for everything."

Adam's description here is analogous in many ways to what sociologist Irving Goffman (1959) called "impression management," or the "control (or lack of control) and communication of information" (p. 208) about oneself. "When an individual appears in the presence of others, there will usually be some reason for him to mobilize his activity

so that it will convey an impression to others which it is in his interests to convey" (Goffman, 1959, pp 3-4). Impression management, according to Goffman (1963), is particularly salient for people who are members of marginalized or stigmatized groups, such as people with mental illness. For Adam, reinventing himself at college meant positioning his bipolar diagnosis as something "left behind" (on the other coast of the country, in fact); in this way, he could avoid mentioning it and thus avoid being identified as a member of a stigmatized and (in Goffman's language) "discredited" group.

**I CAN DO IT ON MY OWN**

This theme captures expressions of self-determination and self-reliance, common in emerging adulthood. At this developmental stage, young people typically re-negotiate their relationships with parents and caregivers and take on more independence and responsibility while exploring the domains of school, work, and love (Arnett, 2004). Many of the study participants expressed a desire for this type of independence and autonomy. Adam explained "I can take care of things by myself – I'm used to that," while Naiyah (22, a college Sophomore) described her decision to live on her own while attending a local community college: "I wanted the feeling of being independent, and of taking care of myself." This motivation to be "in charge" of their lives, however, leads some students to rebuke available supports in college perceived as "special treatment."

***No Special Treatment.***

> "I don't want any special treatment from my professors. I can do the work and I don't need extra help." – Paige

Here, Paige explains her decision to forego accessing academic accommodations at her college; she is one of several students who described not wanting any "special

treatment." Related to this focused code is the idea, also common among the study participants, that accessing accommodations might be perceived by college faculty and peers as "getting away with something," thus should be avoided. In addition, several students mentioned not wanting to "be a burden" regarding asking for academic or mental health help. They didn't want to be perceived as different from their peers or "needy" in any way, thus chose to forego certain services and supports that might be construed as "special treatment."

In addition to not wanting to be singled out, several students also reported wanting to challenge or test themselves in college in an effort to prove that they could, in fact, "do it on [their] own."

***Testing Possibilities.*** Adam described *Testing Possibilities* with his decision to attend university on the East Coast even though he grew up in California:

> "I moved across the country to challenge myself – to see if I could handle it," he says.

He wanted to test himself by living away from his family for the first time, and "doing college" on his own. In contrast, Kathryn's experience with *Testing Possibilities* manifested

after she entered college, and was specifically related to her mental health treatment:

> "I wanted to see if I could be in college without my medication. I don't know why - a new beginning, maybe. I feel happier here [at college], more free, and I just thought, 'I don't really need meds right now. I can't be on Prozac forever!' I was originally given Prozac because of my anxiety, but I don't really have anxiety that bad right now, so I just took myself off of it in the beginning of the school year."

In the above quote, Kathryn expresses both a desire to be a college student without taking psychotropic medication (*Testing Possibilities*), while also conveying the theme IT'LL

BE BETTER IN COLLEGE. With her mention of "a new beginning," and of feeling happier and "more free," she indicates a belief that her mental health will continue to improve in college, making the medication that she relied on in high school seem unnecessary. (It is important to note that for Kathryn, this decision to stop taking her medication without consulting her prescribing psychiatrist from home did not pan out well; over several weeks, she became seriously depressed, experienced suicidal ideation, and was admitted to the hospital at her large urban university's medical campus for four days.)

If *Testing Possibilities* is framed as a form of risk-taking, it represents a developmentally normative process in adolescent and young adult development. And, as is the case with many forms of "risk-taking," the outcomes can be positive or negative, leading to optimal growth or, sometimes, harm. Regardless of the motivation or the outcome, however, testing possibilities for the participants in this study go hand in hand with self-determination and self-efficacy, captured by the focused code *I'm in Charge.*

***I'm In Charge.*** Self-determination is rooted in choice and is the process by which someone controls his or her own life; it is a construct important in both young adult development and psychiatric rehabilitation. According to Arnett (2004), emerging adulthood is "the age of opportunity," and the developmental stage that is most correlated with burgeoning exploration, self-determination, and autonomy. In the domain of psychiatric rehabilitation, self-determination is understood as essential to recovery, and thus is considered a key component of rehabilitative practice and policy (Anthony, Cohen, & Farkas, & Gagne, 2002; Onken et al., 2007). People managing mental illness are acknowledged as in charge of their own lives and decisions, with mental health

professionals tasked with helping clients to set and meet their own individual and authentic goals (Anthony et al., 2002; Corrigan et al., 2012). Common themes in the literature related to self-determination and disability include: living, learning, and working where one chooses; self-advocacy and making one's own decisions; and choosing and directing services and supports to aide in one's recovery (UIC, 2002, p. 1) Many of the participants in the current study described a desire for or actions related to living self-determined lives. As Lily (age 18, and a college Freshman) said, "I always do better when I think that I have control over things. Personally, control means a lot it me. It makes me feel secure." Here, she is describing how having "control" over her daily life and decisions (such as where to live and what college courses to take) helps to guard against feeling "out of control" when her bipolar symptoms manifest.

While Lily seeks "control" in her daily life at college as a way to minimize stress and attend to her symptoms when they arise, Bella describes the importance of "being in charge" of her mental health by deciding whether and when to seek services and support on campus for her depression.

> "I wanted to be in charge of my mental health in college. I didn't want to rely on the university at all. I really wanted to be in charge of my stuff. I didn't want my mom, or anybody else, doing it for me. I wanted to be in charge of my mental health care, and whatever I decided to do, to do it by *my* choice and *my* rules. I really didn't want anybody telling me what to do – which was probably pretty childish, but I really wanted to do it on my own." - Bella

Above, Bella justifies her decision in the Fall of Freshman year to not seek academic accommodations or make an appointment at her college's Counseling and Psychological Services (CAPS) Center, despite the fact that she was in treatment throughout high school and also had an IEP. Like many of the study participants, Bella was reluctant to discuss

her psychiatric disability with staff in college – even with trained mental health and student support professionals - because she wanted to feel "in charge," independent, and able to "handle things" on her own.

Bella goes on to describe her reluctance to seek services at her campus' CAPS Center even when her depressive symptoms returned in the second semester of Freshman year:

> "I kept having issues with my emotions, but I kept, you know, sort of coming from this internally stigmatizing place where it's like, 'You don't need to go to therapy. You should be able to handle this by yourself,' which I know is ridiculous. I guess I just wanted to feel like I was totally in recovery – like so far past any of my mental health issues from high school – that I could get by without therapy. But now I know I can't, and that's fine. I'd rather be going to therapy and be happier than not going to therapy and somehow retain my pride or some other B.S."

Bella's desire for increased autonomy led her, and many of the other study participants, to initially shy away from identifying as someone with any sort of need for assistance. Unfortunately, self-identification as someone with a disability is necessary in order to access counseling, other services, or formal academic accommodations that can make college success and completion more likely. Decisions and behaviors related to disclosing mental health status (what to say, to whom, how, and why) are closely tied to a student's need for autonomy, as well as to his or her need for relatedness to peers. These issues are captured in the theme below.

### THERE'S SOMETHING YOU SHOULD KNOW ABOUT ME

> "Sometimes, when I'm growing closer to someone, I'll just say, 'I think there's something you should know about me.' And then I'll tell them." – Jake

This theme captures voluntary mental health disclosures in educational contexts: when, where, why, to whom, and examples of participants' disclosures and of various people's reactions to them.

***Strategic Disclosure.*** Although many study participants chose not to disclose their mental health status to peers or school faculty or staff (SECRETS & SILENCES), most - like Jack, above - describe "strategic disclosures" to one or more close friends or trusted faculty members in order to (1) increase the intimacy and quality of a relationship; (2) prepare friends to be sympathetic and well-informed supporters; (3) better equip peers to assist in case of a psychiatric emergency, or (4) explain a prolonged absence, sudden drop in grades, or visible symptoms to professors. In addition, certain students disclosed in their college application essays as justification for high school absences or academic difficulties, or simply as a way to describe an important aspect of themselves and highlight resilience. Whether the disclosure is verbal or written, however, or to a peer or a college staff person, the importance of being understood by others ties the various focused codes within the theme THERE'S SOMETHING YOU SHOULD KNOW ABOUT ME together. As Bella explains,

> "Very few people on campus besides my super close friends know *everything* about what I've been through, 'cuz I don't think everyone has to know all those things, but I do disclose certain things to certain people…And a few good things have happened where I disclose to people and they're, like, 'No Way! Me, too!' Just sharing the experiences with somebody who's in the same class, who is in the same school as you – it's the whole idea of you're not alone and people understand you."

Like, Bella, Kathryn finds solace in sharing certain aspects of her mental health history with peers on her college campus, despite her mother discouraging her from sharing this part of herself:

> "When people ask or whatever, I kind of just say I have mental illness ... I usually say the disorder that I have like, 'Oh, I'm borderline bipolar.' I feel like it's more accepted nowadays than it was back in the day. My mom tells me to always be quiet about it and not to really tell anyone except, like, your really, really best friend, but I find that there's a lot of people on campus that struggle with the same things. It's easier to connect with people now, I think, than it was back in the day."

While Bella and Kathryn conceive of disclosing as a way to strengthen and solidify friendships (as well as a method to identify peers with similar experiences), Ava describes sharing part of her bipolar story with romantic partners: "Yeah, I've told my last three boyfriends something was up with me. That's just something that I think comes with that kind of intimacy." In all of these scenarios, telling certain classmates, friends, and loved ones *strategically* about one's mental illness is seen as leading to positive relational outcomes.

***Friends Can Help You.*** In addition to being understood and strengthening relationships, several of the study participants described disclosing to select peers in order to prepare them to provide effective emotional support and instrumental assistance when needed. "I told my suitemates what to expect if I have a panic attack, so they won't freak out and they can help me in the best way," explains Morgan (18, a college Freshman). Lily seconds this sentiment with, "I told some close friends about the medication that I take, so that when we're at parties together, they can help make sure that I don't drink. I could get super sick if I did, and they've been really helpful with that."

***Coming Out "Crazy" At School.*** While many participants described turning to friends for support and disclosing in that relational context, others spoke of "coming out" to peers or faculty in classroom discussions or in written assignments. Much like the

experience of "coming out" as LGBTQIA, students with psychiatric disabilities face the possibility of discrimination when they disclose. In deciding whether to come out at school, high school and college students must weigh potential negative outcomes with the possibility of positive outcomes such as increased understanding and support from peers and faculty, as well as the opportunity to address and rectify stigmatizing misconceptions about people with mental illness. Bella describes one experience of "coming out" at school in her first semester at college:

> "Some of my professors already know, like my *Memoir Writing* teacher knows because I wrote about my suicide attempt and my depression for an assignment. And I told my Psych 101 professor because – well – she teaches Psych!"

In future research, it would be worthwhile to explore whether faculty feel prepared to receive such disclosures, as well as what their views are regarding whether or how to appropriately respond to them. One recommendation might be to develop campus policies and protocols to prepare faculty and staff to receive this type of personal information in ways that respect students' privacy while also offering support and links to campus-based services if and when needed.

In addition to disclosing in written assignments for various reasons, some students also described sharing elements of their mental health stories verbally in classroom interactions – either to educate peers and advocate for mental health consumers, or to explain symptoms when they become visible. Jennifer describes disclosing in a classroom discussion in order to educate and advocate:

> "I was in my Abnormal Psych class, and we were talking about bipolar, and someone said something that was just really offensive and wrong about 'crazy' people, so I raised my hand and said, 'Well I live with bipolar, and I beg to differ…' It's a stigma reduction thing on my part. I feel like as long as I'm comfortable with it, I can use that to my advantage and educate people. It's like,

> ‘hey I'm not at this moment shooting up a school. Big shocker!’ Classmates can come to me and be like, ‘well what's with that school shooting?’ or something. Then we’ll sit down and have a ‘mental illness in the media 101 session.’ A lot of my friends are very supportive.”

Other study participants, like Morgan, describe telling college faculty when symptoms become obvious:

> “Usually I won’t tell a teacher until I have a panic attack in their class and have to leave and then I’ll come back after class and just say, like, ‘Hey, I just want to let you know that I have lots of bad panic attacks. I have OCD – that’s the reason I have panic attacks, and sometimes I’m going to have to leave class.’ I’m like, ‘I’m leaving class because if I stay, it’ll be a big distraction for everyone, ‘cuz whenever I have a panic attack I shake violently and people think I’m having a seizure.’ I’ll explain that, and then most of them are like. ‘You can leave whenever you have to. Just get up and leave quietly.”

Both Jennifer and Morgan found that people responded positively to their experiences of “coming out” at school. In fact, Morgan had disclosed to certain college staff members before she even arrived on campus. She chose to write about aspects of her experience of psychiatric hospitalization in her college application essay – as did one fifth of the interview participants.

***Telling in College Essays.*** Whether students chose to write about their mental health in their college applications or not, the issue of whether to disclose in this format was something that nearly all of the study participants considered. As Adam explains,

> “That was probably the most stressful part of the college application process – to disclose or not to disclose mental health. A lot of people feel like they need to reinvent themselves for the application. They need to come up with something new, or a different perspective. It’s like, do you include mental health or not? Yeah, that defines you, but at the same time, I think it’s complicated. College admissions are very complicated anyway. Everything is complicated if you care about it. I decided I had no reason to do it. It didn’t affect me grade-wise in high school – it was more of an attendance record issue from being in the hospital – and it wasn’t necessarily relevant to the questions they were asking. So I thought, ‘I’m not going to force it. If I comes up, it comes up. If not, I don’t want to purposefully create a sob story.’ That was the other thing – I didn’t want to write a sob story because that’s not the

kind of person I am."

While Adam decided against disclosing in his college application for fear of writing a "sob story" and eliciting pity (related to the focused code *No Special Treatment*, above), Morgan saw her experience as a mark of courage, strength, and overcoming obstacles, and wrote about her mental health despite her mother's apprehension.

> "I felt that writing about my hospitalizations and mental illness was very authentic. It was very *me*, and it was what I *wanted* to write about. So that's what I did. But my Mom and I got into a million arguments over it. She was worried that no colleges would accept me because I think when colleges are looking for students, 'mentally ill' isn't really on their checklist of good qualities. We had a disagreement over how [my application essay] would be interpreted by the readers. She thought they would just view me as someone with a mental illness and someone who might be likely to drop out of school or not succeed, or just be a student who needs more support than they could offer. But I viewed it as, like, 'Look at all this shit that I have to deal with. Doesn't this make me a kickass person?' That's what I was focused on, like, 'Look at how strong I am. Look what I've had to overcome, all while trying to be a good student.' I mean, I've already been through the hardest things, so now, come what may, I'm pretty sure I'll succeed. "

Like Morgan, Ava's mother was skeptical of her disclosing her mental health challenges when applying to college initially, as well as when she transferred from her first college to a different university after three medical leaves at the initial school:

> "I think my mom was - you know, she's very supportive of me but she's very wary about what we write when we write to schools. Even when I wrote to Z University, I didn't necessarily say that I tried to kill myself and that's why I had left my last school. That's not what I wrote in the letter. I wrote that I had an adverse reaction to medication withdrawal, which was true. Because I'd stopped taking my meds and I became suicidal…But kind of the smallest amount of truth is what we've generally written."

***Reactions to Disclosures.*** Whether in person or in print, the study participants were well aware of how others might receive their disclosures. And, in actuality, some recipients of mental health disclosures were kind and considerate, while others were less

so – or simply unsure of how to respond. Bella, Kathryn, and Jennifer, above, described positive reactions from friends to various mental health disclosures, with some peers responding by coming out with their own mental health diagnoses and struggles. Other study participants, however, were faced with confusion or simply with silence. Here Max describes preparing to depart for a medical leave in the middle of the first semester of his Freshman year:

> "I actually did tell my roommate about the depression when I was packing up for my medical leave, and it didn't go nearly as well as I thought it would. He didn't really say anything. It was kind of awkward. I would have thought he would at least have said, 'I hope you get to feeling better, or something like that, but he didn't really say anything at all. I don't know if he just didn't know what to say. I'm not sure."

In contrast to Max's roommate, Jake perceived that the recipient of his first mental health disclosure in college over-reacted, putting Jake's privacy in jeopardy and leading him to question his chosen college's mental health policies. Here he describes disclosing in his college application essay, and the unexpected fall-out: "I wrote about how I came out to my entire high school about my OCD, and then how I ended up starting a club called *Brains Without Borders* to teach peers about mental health and mental illness," he says. After receiving his acceptance letter to his first choice school (a highly selective small liberal arts college), however, Jake received another, unexpected missive.

> "I got an email from [the director of the campus Counseling and Psychological Services Center], which I was kind of surprised by. It said, 'Admissions passed along to me that you've dealt with a mental health issue in the past. If you ever want to come talk to me about it and set up an appointment with CAPS, we're always available.' Apparently admissions had passed along to him, from my essay, that I had mental health issues. They never told me that they did that, though, and I had a very strong expectation of privacy."

Though well-intentioned, the message from the CAPS director left Jake feeling as if his privacy had been betrayed, as the essay meant solely for the admissions committee had been shared with other campus staff without Jake's consent.

> "I think it was well-intentioned, but even something that's well-intentioned, that doesn't kind of follow a strict privacy protocol, that's….On the one hand, I was like, 'It's nice that he's reaching out.' But at the same time, I was very disturbed that that implicit privacy was breached. And *very* quickly – before I even got here. It's kind of this balance between, 'They're trying to look out for me.' But at the same time, I didn't want them to know that. I never *intended* for them to know that."

Ironically, the CAPS director's note left Jake upset and wary of CAPS; he actually decided not to ever use their services once on campus, and instead relied solely on tele-therapy with his psychiatrist from home. "The school's response - it definitely had an unintended effect," he says.

**I HAVE A DISABILITY? *ME*?!**

This theme captures students' conceptions or descriptions of being "disabled" (or not), as well as feelings about academic accommodations offered through Student Disability Services (SDS) on campus. The question mark in the theme's label implies a skepticism regarding whether one is "disabled." This is related to whether and how SDS is seen as relevant, and/or if mental illness is even considered a "real" disability by both study participants and SDS staff. "I was, like, 'Wait – I have a disability? *Me*?!" says Paige incredulously, and Max seconds this sentiment with: "I never really thought of it as a disability."

Many study participants are reluctant to disclose psychiatric disabilities to teachers, campus-based mental health professionals, or even to SDS staff. This reluctance is not always due to stigma or fear regarding losing friends or being judged, however; just

as often, a desire for increased autonomy and independence seems to lead some students to shy away from identifying as a student with "special needs." Unfortunately, self-identification as someone with a disability is necessary in order to access academic accommodations at the college level.

The majority of interviewees do not identify as having a "disability," and they do not identify themselves as such with campus SDS. This may be partially due to the fact that only three of the 26 interviewees were identified as having emotional-behavioral disorders (EBD) in high school, thus were granted special education services and had Individual Education Plans (IEPs) via the IDEA federal legislation (Individuals with Disabilities Education Act). The remaining interviewees, despite having been diagnosed mental health disorders as adolescents, were not identified by their secondary schools as having EBDs, and were not granted any sort of academic accommodations or other services. It seems likely that if more of the interviewees had received academic and social supports through Special Education, that more of them would have been familiar with "disability" legislation, and might have self-identified at SDS to access academic accommodations in college. This is an area ripe for future study, re: are secondary school students with IEPs any more likely to access academic accommodations in college than students with mental health diagnoses who do not have IEPs?

***Are Those Services For Me?*** Many of the interviewees expressed confusion about the mission and purpose of SDS on college campuses, with most stating a belief (at least at the beginning of college) that SDS is not intended for students with mental health challenges or psychiatric disabilities. Upon learning that she qualifies for services at her campus SDS, Paige exclaimed: "I thought Student Disability Services was just for people

with *physical* disabilities! I mean, how would you know that? I just thought, 'This doesn't apply to me,' when in actuality I guess it does." Like several of her peers, Paige notes a disconnect between what Student Disability Services can actually do for students, and what many students understand as the office's mission. Many interviewees, like Paige, described thinking that SDS is for students with mobility issues, visual or hearing impairments, and/or learning disabilities, and that it is "not for them." Despite the existence of the Americans with Disabilities Act, and the explicit purpose of SDS offices, messages of their existence and services is often muddied – or does not reach students at all.

***[No Special Treatment.]*** **This focused code is also part of the theme I CAN DO IT ON MY OWN, described above.**

***Getting Away With Something.*** While some interviewees were not aware of SDS and the possibility of accessing academic accommodations there, others chose to forego this resource for fear of being perceived as somehow exploiting the system for personal gain. As Morgan explains, "I don't want my professors to think I'm taking advantage of accommodations, or getting away with something. That's why I don't use them." Several of the interviewees concurred, making this focused code a primary reason for not utilizing accommodations, and for shying away from identifying as a person with a disability.

It is noteworthy that in her qualitative study of five young women with emotional behavioral disorders in college, Stein (2012) found that the participants in her study often did not disclose to college faculty or staff because they did not want to "appear weak," or as if they were "getting away with something." My findings complement Stein's, and

point to what may be a deep desire among all young adults - whether they have psychiatric disabilities or not - to be independent and efficacious, while also fitting in with peers. In addition, several of my study participants expressed a fear that they would, in fact, "take advantage" of accommodations if given the opportunity; to avoid this situation, several opted to forego accommodations altogether, or – like Bella – strategically chose which ones to employ.

> "I get extra time on exams, and I can take the exams outside the classroom, but that's really it. That's all that I wanted transferred over from my IEP in high school. I met with the accommodations counselor here and we picked and chose which ones we thought were appropriate. I really didn't want to give myself the safety net of having that two to three extra day extension on assignments, because I felt like if the situation was dire enough that I really needed an extension, I could just talk to my professor and explain the situation, instead of feeling like, 'Oh, I have the extension, so I don't have to do it right now.' I just felt like that would really promote some sort of me taking advantage of the accommodations that I had." – Bella

***Accommodating to Accommodations.*** This focused code captures decisions related to and experiences accessing or receiving academic accommodations in college. While certain students sought SDS supports of their own volition, others were encouraged by parents or caregivers, and/or were mandated by their university as a stipulation of return to classes after a psychiatric medical leave. Freshman Bella explains the ease with which she accessed accommodations while maintaining her privacy here: "At the beginning of the year, I got academic accommodations from the university because I had them in high school. Then I gave a letter to all of my professors explaining that I have accommodations, but it didn't specifically say *why* I have them. And that was it." She goes on to admit, however, that her mother was the catalyst that led her to go to SDS so early in her first semester as a college student. "My Mom really encouraged me

to get accommodations – I probably wouldn't have done it otherwise. But even if I don't really need them, I guess it's better to have them and not need them than the other way around."

In contrast to Bella's voluntary use of SDS and accommodations, Adam, Max, and Ava were required to meet with SDS and self-identify as students with psychiatric disabilities upon returning from their medical leaves – despite the fact that none of them felt that they required academic accommodations. As Adam explains,

> "I had to sign up for accommodations when I came back from medical leave – they wouldn't let me come back otherwise. But I didn't really feel like I needed accommodations. I mean, I'm an 'A' student, and I've never had accommodations before, so why do I suddenly need them now?"

While some students were mandated to access accommodations despite feeling that they were not necessary, other students reported facing barriers in trying to secure accommodations when they realized that they actually needed them. Nina describes her difficulty here:

> "It always has to get like I'm going to get kicked out of school or I'm not going to be able to register or I'm homeless. It has to be a crisis moment for me to actually take action, and then it doesn't really make sense because the SDS people are like, 'Why didn't you come to us *earlier*?' and I'm like, 'Well you've obviously never had depression!'…I've been talked down to and patronized. They didn't take my condition seriously at all."

Nina is one of several interviewees who described not seeking services at SDS until a "crisis" such as nearly failing a class or feeling panicked at impending exams. In addition, she, Max, and others remarked that the available and/or most common accommodations (extended time on tests and for assignments) are not necessarily very helpful for students with psychiatric disabilities.

"For bipolar disorder, specifically, I get periodic absences and extended time to

> finish work…It just feels like sometimes I get overwhelmed easily even though I'm very capable of the work. Sometimes I just need a day where I don't go to class... I would actually prefer something like a week off, but the school won't give me a week because they say that would be too long. If I get a Friday here and Monday there, that has to do." – Nina

> "When I talked to the disability services, the only things they could offer me were longer times on tests and maybe a note-taker, but neither of those would really help with the problem I was facing, which was difficulty concentrating due to my depression. I mean having a note-taker isn't really going to help with that." – Max

Lily was one of four interviewees to explicitly mention needing a single room, and viewing this as an important accommodation conducive to her well-being and ability to succeed in school.

> "I feel that a very important thing about accommodations is that people should consider whether or not you need a room to yourself. Because sometimes if I'm depressed, I need to be alone. I won't feel comfortable crying in front of someone else, and crying is an important process of trying to just relieve tension. Also, a part of my mood swings is from being around too many people for too long. Sometimes I just need to be alone, and when I'm alone, I actually don't get many mood swings. I'm just ... I'm alone, there's nothing that can hurt me in my room." - Lily

(Note this this is related to the *Physical Spaces* focused code in the SAFE SPACES theme, below.)

And, finally, four of the twenty-six interviewees chose to access accommodations on their college campuses as new Freshman, but only for learning or physical disabilities, and not for their concurrent psychiatric disabilities. This highlights the issue (mentioned above) of not necessarily recognizing that students with all types of disabilities can utilize SDS's resources.

**RELATING FOR RECOVERY**

This theme includes mention, description, or examples of receiving and/or giving social support or engaging in relationships that benefit one's mental health, sense of well-

being, and over-all recovery. This theme also includes focused codes related to study participants teaching or prepping friends and others to be better equipped to offer appropriate support if and when it is needed.

***Relational Recovery.*** There is a rich literature pointing to the importance of peer relationships in both emerging adult development (Arnett, 2004; O'Connor et al., 2011), as well as recovery in mental illness (Learny et al., 2011; Schon, Denhov, & Topor, 2009; Tew et al., 2012), and many study participants spoke eloquently about the importance of relationships with classmates, friends, and romantic partners to their own recovery journeys. Morgan explains that "sometimes your friends are like medicine," echoing and expanding upon the words of researcher and consumer activist Pat Deegan (2005), who wrote of the importance of "personal medicine" in recovery. While Deegan highlighted personal activities that give life purpose, boost self-esteem, and decrease symptoms, Morgan is describing how supportive friends and relationships are as essential to her ongoing recovery as her medication and mental health care providers.

***[Friends Can Help You.]*** **This focused code is also part of THERE'S SOMETHING YOU SHOULD KNOW, above.**

Morgan gives an example of her friends acting as powerful "medicine" when she describes how she taught her Freshman suitemates to best support her during panic attacks.

> "I usually grab someone who I feel close with when I'm having a bad panic attack so I can talk to them because if I can distract myself from my panic attacks then I start to feel better…So during my panic attacks I try to get people to ask me lots of questions so they'll distract me. I need someone there to talk to me, to ask me a ton of questions like, 'how was your day? What's your favorite color? Blah, blah, blah.' But then also, walking around is something I've always done, too. So I ask my suitemates to go for a walk with me sometimes, too."

Kendall is clearly relying on trusted friends to offer her instrumental assistance during times of crisis; however, she also understands and values the general support and feeling of connectedness that friends offer. Bella, also a Freshman, agrees: "interpersonal relationships to me are everything," she says. "That's one of the most important things – just having the right healthy people around me who know that I have this, and I deal with it, and knowing that they understand it. Even if I don't talk about it with them all the time, just knowing that they get it and they don't judge me for it is so important."

Ava, too, expresses finding solace in sharing some of her mental health history with a friend (linking *Relational Recovery* here to THERE'S SOMETHING YOU SHOULD KNOW and *Strategic Disclosure*, above).

> "My friend actually shared this wonderful quote with me. I might mis-phrase it, but the sentiment is so beautiful. It's like 'when you experience joy, when you find something that you're excited about and you share it with a friend, that joy is multiplied. But when something is troubling you and you share whatever that may be with your friend, your pain is divided.' I think that really applies when you're having a mental problem. You're not alone in dealing with it, you're having a witness to that pain. I'm actually getting chills right now even thinking about it. It's something really powerful that can't be under-estimated."

***Social Support – It Goes Both Ways.*** Several study participants describe not just receiving support from peers and friends, but offering it, as well. Bella explains that several of her new friends in college also have mental health challenges, and that confiding in and supporting each other is invaluable.

> "I have friends here who also have depression, so they really understand it. So I can sometimes just be like, 'I feel like shit today,' and they're like, 'Me, too. I don't know why.' We can be like, 'Let's go outside,' or 'Let's go change our environment,' or 'Do you want me to come by?' It's really supportive, but it's never like I'm relying on them for therapy or that kind of stuff. It's just nice to know there's friends here and at home who care about me and want to see me succeed."

Adam, also a Freshman, describes how he shares some of his hard-won expertise regarding coping with stress and managing anxiety.

> "There is a girl on my floor the other day and she was freaking out because her high school was super easy and she's used to being able to easily get straight As, and now it's hard, and she's freaking out over that. She's basically having a panic attack. She's like, 'Oh, my God,' going on and on. I'm like, 'Okay, as dumb as it sounds, try some deep breaths. Go have a cup of warm water. Lie down. Do basic things like that.' She does them and she's like, 'Whoa. I feel better.' She's like, 'How do you know that?' I'm like, 'Well, because I go to therapy.' Then she's like, 'Why do you go to therapy?' 'I'm bipolar.' She's like, 'I never would have guessed.' I was like, 'There's no reason for me to tell you, but you asked. I'm not going to hide it from you.'"

In this example, Adam shares part of his lived experience (linked to *Strategic Disclosure,* above) in an effort to help someone else. In doing so, he reframes managing his own mental illness as a valuable set of skills that he competently employs to aide himself, as well as his peers.

***[Relational Spaces.]*** This focused code is described in more depth, below (see SAFE SPACES), but it is important to note that positive and caring relationships – whether they directly address mental health issues or not – are key components of the study participants' experiences of recovery. Such relationships act as SAFE SPACEs, and without them, young people can feel isolated and excluded. Ava describes feeling a lack of social support and authentic friendships as her depression worsened in Freshman year:

> "I remember feeling like all the friends I thought I had were actually my boyfriend's friends – a feeling that I wasn't connected. As I started to really burn out from all the partying that we were doing and get really low, I didn't feel very supported. But then again, I didn't really reach out for help, either. I don't think I've ever really learned how to do that from friends."

Indeed, asking for emotional support may well be a learned skill, but one that is seldom modeled or taught explicitly to youth. Parents, educators, and healthcare providers might consider ways to teach youth to seek help when needed in appropriate, authentic, and effective ways.

**SAFE SPACES**

This theme explores the concept of having or desiring a "safe space" while a college student (both literally and figuratively) in which to live, learn, work on one's recovery, manage symptoms, disclose if desired, ask for help, and connect with trusted peers. Examples of seeking and finding SAFE SPACES include making friends and "feeling understood," joining clubs and organizations on campus, and finding peers who also have lived experience of mental illness and recovery.

***[Relational Spaces.]*** Lily, a Freshman, describes how she feels knowing that her new college boyfriend also has a psychiatric disability:

> "My boyfriend has bipolar, too, and it's nice to have someone who gets it. I can always be honest around him and I don't have a lot of places to do that."

Here, she is describing the relational "space" of her connection to a romantic partner who shares a similar history, as well as the "space" of a private conversation with a trusted confidante. Other "spaces" that are both relational and physical are campus clubs and organizations - particularly those that are supportive of students with mental health challenges. Here, Kathryn describes joining her campus chapter of Active Minds, a national non-profit with chapters on nearly 300 American college campuses, whose mission is to "empower students to change the perception of mental health on college campuses" (www.activeminds.org).

> Laura: "Are you a member of any on-campus organizations or clubs?"
> Kathryn: "I am. It's called Active Minds, and it actually just started here this year."
> Laura: "How did you first hear about it?"
> Kathryn: "I saw a flyer for it and they had a meeting date and I just went to the meeting and it was really cool. I liked it a lot. They do a lot of fundraisers, and they have movie night for the club on Mondays. The meeting that I went to most recently, they had a PowerPoint presentation on mental illness in the media. They talked about TV, Film, and music, and how people portray mental health. That was pretty cool."

While Kathryn joined an existing chapter, Bella went about founding an Active Minds chapter on her campus.

> "I really felt like I wanted to help other people not feel as alone, isolated, and totally uneducated about mental health as I did when I was going through all that. That's why I started the club and became a mental health advocate… I felt like I was ready to help other people about it, because I felt like I was stable."

Morgan became a member of another type of mental health-related campus club:

> "I am in this group that just started, like, last year and it's called [this University] Speaks Up and they are basically just trying to create more dialogue about mental illness on campus. We're in the process of making a website where you can connect to counselors or call a resource line. Then we've created all these videos, too, interviewing students talking about their mental health issues so that other students can see what people have gone through, and that they're not alone."

These organizations give young adults the opportunity to participate in meaningful and authentic ways to support health and wellness – both their own and others' – while also creating a space for interactions with same-age and like-minded peers. In addition, the clubs are venues to educate campus communities about mental health, stigma, treatment, help-seeking, suicide prevention, and recovery. These "spaces," in many ways are both physical and relational incubators for mental health advocacy and activism, with young adults with psychiatric disorders often in positions of leadership.

***Physical Spaces.*** SAFE SPACES that are *physical spaces* are equally important to many of the interviewees. Several study participants, including Alex, Max, and Lily, described the importance of having a sanctuary in their dorm rooms. In his Freshman year, Max shared a room with one roommate and had this to say about the experience:

> "I got pretty lucky because I got along with my roommate fairly well, but it was always stressful when I was feeling suicidal or just really depressed, because I didn't have a place to go back to, and be alone."

Lily requested a single room in her college application, and was lucky enough to get one.

> "I feel that a very important thing about accommodations that people should consider having is whether or not you need a room to yourself. Because sometimes if I'm depressed, I need to be alone. I need to be able to figure it out; I won't feel comfortable crying in front of someone else. I feel like, also, a part of my mood swings is from being around too many people for too long. Sometimes I just need to be alone, and when I'm alone, I actually don't get many swings, because there's no one around for me to bounce off of. ... I'm alone, and there's nothing that can hurt me in my room."

Adam had difficulty living in a suite with four other students his Freshman year, and requested a single room after returning from a medical leave in his Sophomore year.

> "During the 2014-2015 academic year, I lived in a suite with four other individuals. I didn't have a place where I could study, or have the quiet for a good night's sleep – which I need. It was also always a mess. But aside from that, I think the most important thing I lacked was personal privacy. Currently, I have appointments with my psychiatrist via telemedicine. Because my living space last year was shared, I always had to seek out places where I could have my phone calls with my doctor in private. I don't want to disclose personal information in front of my roommates!"

He goes on to explain that having "a space to myself" (a single dorm room in his Sophomore year) provides him with "complete privacy to help manage my condition."

Like Adam, Beth describes how her experience living in the dorms as a Freshman did not feel "safe."

> "I went to the dorms and I just didn't feel comfortable. It was all these people, shared showers was a huge personal trigger for me because I had lived in group homes where I had been bullied and horrible stuff like that. I was not comfortable with the shower. I was not comfortable with someone living in my room that I didn't trust or didn't know at all. It was a very triggering experience personally because I felt unsafe. I felt uncomfortable, and because of that I stopped taking my medication because I thought that it wasn't working."

These students' experiences point to a need for academic accommodations to include, when needed, single dorm rooms for certain students. Indeed, having "a room of one's own" is not just a luxury; for some, it is a therapeutic necessity. Unfortunately, colleges and universities currently seldom consider single rooms as a form of academic accommodation.

**TIME OUT OF SCHOOL**

This theme reflects both voluntary time away from school to focus on recovery, as well as unexpected or involuntary medical leaves. "Time away" could be short-term (e.g. a result of side effects due to changing medication) or long-term (e.g. a hospitalization or extended medical leave for intensive treatment at home). The theme also includes descriptions of transferring among colleges, as well as experiences and challenges related to returning to school after an absence. Finally, the theme includes conceptions of "lost time" in school, as well as related lessons learned.

***Missing Class.*** A very common experience among the interviewees was missing class due to symptoms, with absences ranging from one day to an entire semester or year-long medical leave. Here Beth describes missing classes and no one noticing, or taking action to inquire about her well-being.

> "At some point I finally had to admit that something was wrong. I finally admitted it in late October because I hadn't attended classes since mid-September and I knew I wasn't going to pass. I knew this was getting really bad. But no one

> reached out to me. No RAs came to check on me. My roommate, I guess she didn't know what to do because she let me just sit around. It's not her fault - I mean I just stayed in my room. I literally just never moved from that spot so I guess maybe she was suspicious and didn't say anything…No one came to at least look in on me and be like, 'Hey there's a student that's been ...' especially when I was pretty vocal in class. I was always pretty vocal in class. When I'm gone, professors notice…But still nobody reached out."

The onus was on Beth to take action to avoid academic failure, but, as she explains, it was difficult to motivate when she was extremely depressed. Reflecting back, she wishes that someone had reached out to help her, as opposed to making her responsible for her own help-seeking.

In addition to describing the challenge of missing class and trying to maintain good academic standing while managing symptoms, many of the study participants expressed desiring academic accommodations that would afford them flexibility in attending classes, and/or excused absences from class without penalty (this is related to *Accommodating to Accommodations*, above).

> "I'm trying to get excused absences [from Student Disability Services] because sometimes it's hard to concentrate and go to class. I think I have more absences than the school allows right now, too. I don't really utilize the extended time on tests. It's really the absences that are hard for me." – Kathryn

All nine of the interviewees who accessed accommodations on campus were granted extended time on tests, and many were also offered addition time to submit assignments. However, there was over-arching agreement that these accommodations were not sufficient, and, as stated above, that the episodic nature of mental illness may require accommodations to the academic calendar or one's class schedule. In a word: not simply *more* time, but a different and more flexible approach to time in school.

***Hospitalizations and Medical Leaves.*** Seven of the 26 interviewees (27%) took medical leaves due to their psychiatric disabilities at some point during college, with one of these students, Ava, taking four leaves in four consecutive Fall semesters, and has mixed feelings about how these mandated leaves were handled.

> "I guess they do that with a lot of students. I think that can even maybe add to the feeling of being stigmatized. 'No, you're not well enough to be here,' they're saying. You don't know if you're well enough to be here or not, like, 'Come back when you're not sick.' I don't think that's a good attitude…despite what might be good intentions, sending someone home isn't necessarily the best option. Because sometimes, it's not necessarily medical treatment outside of school that you need. You may not need really intensive care sometimes. Sometimes you need a life change. And sending somebody where they're going to be isolated is precisely the opposite of that kind of life change that you need in that moment."

Ava was initially told she that she would have to pay for each of the Fall semesters that she did not complete, and she had to fight with her school's administration to avoid these costs.

> "The only accommodation I had was they didn't charge me for the classes that I dropped. I had to write a petition for that and I had to explain on the petition that I had been hospitalized and I was dropping the classes later than the drop deadline. It was only actually a week or two after the deadline for dropping, but I still had to do that. And eventually they made an exception and didn't make me pay for the entire semester. Thank God. I've heard of colleges doing that to people."

While Ava was told that she had to take a leave of absence after she expressed suicidal ideation, other interviewees asked for leaves of absence voluntarily.

> "The idea was to take a leave and then I'd still be able to come back in the Spring, and I've have only 'Ws' on my transcript, so no GPA issues or failure…But they (the university administration) were very, like, patronizing. They were, like, 'Frankly the only time we did this was when some guy had an actual problem because his wife was shot in a bank robbery.' Like when someone has *real* problems, we'll deal with it. All the time my problems were dismissed as moodiness, or they weren't real, or at best I was told, 'Well you should have come to us sooner.' (My first university) was incredibly unsupportive. My professors were nowhere to be found, not remotely supportive. I didn't receive a peep from any professor." - Beth

While Beth faced stigma and rude behavior, Adam describes a convoluted and unclear process for taking a medical leave at his university.

> "There really was very little structure to the leave-of-absence process. It was definitely confusing and took a lot of time. It was a time crunch, actually, 'cuz I was trying to get all these documents signed off on before Mid-terms because that was why I was taking the leave – to protect my academic record. I really don't want to tank in grades." –Adam

The process of arranging for his own leave caused Adam undue stress and anxiety – on top of the symptoms that he was already experiencing from a change in medication. This medication change caused side effects including fatigue and difficulty concentrating, making it impossible for Adam to prepare for his Freshman Spring mid-term exams. In order to avoid failing the exams, he decided to take a leave of absence for the remainder of the semester, and assumed that returning in the Summer would be straight-forward. Unfortunately, like several of the study participants, Adam found that returning to school was a more stressful experience than preparing for his leave.

***Trying to Return.***

> "I was getting a very strong impression that they didn't want me back that early [after just a one-semester leave]. But I dealt with this whole thing by myself, I didn't have anyone do anything for me. The only person who actually tried getting anything for me was my psychiatrist, and I coordinated that. That was one thing that I told [the administration], too. I'm like, 'Look, who's doing all of this? *I'm* doing it, so clearly, I have the level of maturity necessary to be independent and take care of my own stuff.' So why didn't they want to let me back in?"

Like Adam, Ava faced barriers when attempting to re-enroll after her psychiatric medical leaves, including having to re-apply to her college, do an in-person interview with the Admissions Office, sign up for academic accommodations through Student Disability Services, and agree to meet on a regular basis with a therapist at the on-campus counseling center. All of the paper work and appointments seemed burdensome to her,

and she was left feeling ostracized and unwelcome back at her college, despite their strong desire to continue in higher education.

> "I want to be able to continue my education. When that is made more difficult for me, it has a huge effect on my mental health and my recovery because I identify with being a student. I want to do well and complete my degree and go on and have a profession. Not being able to do that because of different roadblocks put up by various institutions is ultimately not conducive to my mental health…Recovery isn't like a lot of physical problems, where you're sick and then you're better. When you have a mental vulnerability, it can really resurface at any time. It's episodic. So there's got to be a better way - not just an all or nothing way." - Ava

In addition to dealing with institutional policies (or lack thereof) that can complicate re-entry after medical leaves, study participants also had to negotiate whether and how to tell college classmates where they had been, and why (this is related to *Strategic Disclosure*, above).

> **"**I don't remember how I explained it to [my college friends] at the time, really. I guess I just told them I was taking some time off. I don't think I really told people that I had been in the hospital. I tend not to tell people that. There are very few people in my life that know that I've ever been hospitalized." - Ava

> "I was like, 'Something came up and I had to go back home' kind of thing. I didn't feel like I had to explain anything to anyone. It's my situation, and I'll deal with it." - Adam

***Transferring.*** While twelve of the interviewees (46%) took medical leaves at some point in college, ten (38%) transferred between institutions at least once. Five of the ten students who transferred also took at least one medical leave, and this leave always took place immediately prior to the change in schools. That said, transferring is often associated with time away from school due to symptom and treatment management. And entering a new college or university often means starting over in terms of finding and accessing resources. When Ava left her first college (a small, elite, liberal arts college in a suburban) after four medical leaves in four consecutive Fall terms, she took some time

off and lived at home for about a year, and then matriculated at an Ivy League institution in a large urban center. She continued to live at home with her mother and commute to school on days when she had classes. During her first semester, however, her depression worsened and she was concerned that her academics were being affected. She went to the campus-based counseling service to seek supports to stay in school, but was advised, yet again, to take a medical leave.

> "When I went to the counseling service here, I don't think there was any talk at all of what they cold do for me academically. I think she actually just suggested that I go to a hospital. They didn't connect me with Disability Services or anything. Even the Counseling Services people don't seem to think of that right away. Maybe they were more concerned about me not being in school at all at that point. Anyway, I wasn't given the option to go there [to Students Disability Services] for help. I think that should definitely be more intertwined with the counseling and other supports." - Ava

Here, Ava emphasizes the point that she desperately wanted to remain in school, and – in fact – was seeking advice and support from the counseling center so that she could do that and succeed academically. Instead, however, she was advised to leave school again and was not told about the services academic accommodations available to students with disabilities, and how these might benefit her. Ava did remain in her second college without taking a medical leave, but she did spend several days in the hospital when her depression became so bad that her suicidal thoughts returned. She managed to make up her missed work, however, and maintained a 4.0 GPA despite her struggles.

***Lost Time.*** While Ava accepted that her medical leaves made it impossible for her to graduate "on time" with her initial entering cohort of students, several other interviewees expressed despair at the idea of "being behind" their peers, or of "losing time" due to symptoms, medical leaves, or hospitalizations.

> "I really don't want to be behind all my classmates because of my medical leave. I feel like I lost time. A *lot* of time." - Max

Here, Max expresses a desire to not "fall behind," and says that he feels that he has "lost time" during the medical leave that he took from his first university, despite the fact that his health improved during his time away from school. After experiencing severe depression and suicidal ideation, Max walked himself the University Medical Center and into the Emergency Department. He was admitted for 72 hours, and then, under medical advice, decided to take a voluntary leave from school. His university, however, mandates that students take a full academic year off, and since Max left halfway through the Fall of his Freshman year, he could not return to school until the following Fall. In the interim, he moved back home to a rural Midwestern town and underwent intensive outpatient treatment for his mood disorder. He re-applied to his school and was re-admitted, but discovered that he would have to start over and begin again as a new Freshman. Dismayed that he would "lose" even more time, he investigated options at other schools.

> "Apparently from all of the college courses I had taken during high school and everything, I ended up being able to enter as a junior at [Big State], versus still being a freshman at [Initial, Elite University]. That's what made me choose to go back to school at [Big State] instead....I was happy to be a Junior instead. You know, and make up for some lost time."

Beginning again as a Freshman was not acceptable to Max and he chooses, instead, to go to Big State to "make up for lost time." It may be that he identifies primarily as a college student and a scholar, and not as someone in recovery who may need to take time away from school periodically throughout his higher education experience. Indeed, Max's journey seems to be one of synthesizing these two identities (a scholar, and a person with a psychiatric disability) into one, integrated identity that affords him a sense

of purpose and allows him to pursue his personal and professional goals.

## FINDING PURPOSE

This theme captures descriptions of seeking and/or finding meaning in life. It includes mention of having a purpose, belief, goal, activity – or even a career plan – that is meaningful to oneself, but that also transcends the desire for simple personal gain. Damon, Menon, and Bronk (2003) describe "purpose" as "a stable and generalized intention to accomplish something that is at once meaningful to the self, and of intended consequence beyond the self" (p. 121). Seeking and cultivating a sense of purpose is understood to have a developmentally adaptive role (Bundick, 2011), and is particularly salient in youth and young adulthood. Across the life-span, purpose is widely perceived as essential to maintaining good mental and physical health (Boyle, Buchman, Barnes, & Bennett, 2010; Hill & Turiano, 2014; Koizumi, Ito, Kaneko, & Motohashi, 2008), and many of the interviewees describe wanting to find or create meaning in their lives. In addition, many describe being a student or attending college as a "purpose" that is essential to their ongoing recovery.

### *[School As Motivator].*

> "I've kind of learned that you can't really just plan on going somewhere and hoping that your problems will go away once you get there. You gotta' find something that gives you meaning or purpose. And even though I took a medical leave, I think that might have been kind of harmful, too, because college was my purpose…I can't really get over my depression, I think, until I go back to school. Because since I've been home, I feel like I don't have much meaning in my life, or purpose, because I've just been so bored and lonely. But I think once I get back in school and have, like, a purpose in my education and doing my homework and classwork, I think I'll do better." - Max

Max recognizes that being a college student is beneficial to his mental health, while being home on medical leave increased his feelings of isolation. Ironically,

although his clinical depression symptoms improved during his long-term outpatient treatment, his feelings of boredom and sadness about not advancing in school and pursuing his education goals increased. Both he and Ava, below, view being a student as their primary purpose at this point in their lives.

> "When you have somebody who's depressed, as long as they're not so depressed, they can't even get out of bed, I think one of the best things that you can do is give that person something to do…I know that school is very motivating for me. I've always done very well. It gets me out of my head. It gets me into doing something that is productive for my future and for myself." – Ava

***Helping Others.*** The desire to or experience of helping others is prevalent among the interviewees, and often takes the form of sharing mental health expertise with peers, as Beth describes, below.

> "I've learned to advocate for myself and find services for myself, which makes me a good researcher…I mean, I joke that I'm already sort of a health care coordinator because I've helped my friends sign up on the healthcare exchange at our university, or I'll ell them, 'have you got in contact with this or that service?' I have a friend that was having issues and I was like, 'why don't you go see the school counselor?' They're like, 'you shouldn't know this' and I'm like, 'But because of my own mental health, I do!'"

In addition to assisting friends with advice and recommendations, nine of the interviewees expressed a desire to pursue professions related to mental health in order to help other young people struggling with psychiatric disorders.

> "I want to be a high school counselor so I can work with kids who have the same problems that I did." – Sophia

> "I'm pre-med because I want to be a pediatric psychiatrist" – Ava

> "I want to be a neuroscientist and do brain research related to OCD." – Morgan

> "I want to be a psychiatric nurse practitioner to help people – especially girls with depression and eating disorders." – Mia

These interviewees are explicit that their career goals give them a sense of purpose, and that these goals are informed by their own lived experiences of recovery.

***Mental Health Advocacy.*** Seven of the interview participants described doing some sort of mental health advocacy work while in college. Bella shares that "I'm starting a chapter of Active Minds on my campus. Their slogan is 'changing campus conversations about mental health,' and we totally need that!" She goes on to say:

> "As I got older, what bothered me a lot was the fact that people were so ashamed, and that *I* had been so ashamed of my mental illness. I realized more and more how people judged other people for their brain chemistry, which to me was just ridiculous. So I really wanted to start something to change all that… I just want people to feel comfortable to be like 'hey, I was in the hospital.' And for people not be like 'you're crazy!' but for them to say, like, 'I'm really sorry, that sucks.'"

Lily became a peer counselor on her campus and had this to say:

> "It sounds funny that a person who has problems – well you wouldn't think that I'd be the right person for it because I have bipolar disorder. At first I was like, 'I'm a phony, who am I kidding?' but then I realized that just because I have bipolar doesn't mean I can't do these things. Maybe it means that I even have *more* experience and insight."

She goes on to say:

> "People will call peer counseling before they call the Counseling Center - they just want a peer. A lot of people just want to hear someone their own age, but they don't want to talk to their friends about it because they don't want to be judged by their friends, and I can understand that."

**THE (PATIENT) STUDENT**

This theme captures how study participants see themselves as students, as well as their aspirations to attend and complete college. The theme also includes mention of desire to stay in school and/or continue one's education despite mental health challenges. And, finally, the theme addresses students' academic identity development related to the process of seeing oneself first solely as a student, then being challenged by an identity as

a "patient," and – eventually - integrating one's academic and mental health identities into that of a "patient student." Here, the term "patient" does not refer to a student's medical or mental health status, but, rather, to his or her acceptance of the possibility of a path through college that may be more circuitous and protracted than the conventional four-year passage. Such a path through higher education requires patience and is conceptually linked to the concept of "lost time," above.

***Engaging in School.*** This focused code captures expressions of participating in school, both academically and socially, as well as developing strategies to navigate and succeed in school while managing one's mental health.

> "I have no other life than school, but I'm very happy with that, though. My circle of friends, were all very dedicated to school. It's not like we live in the library, but you do have some crazy partiers at school, and I'm not part of that group. I definitely enjoy my college experience while sticking to the books." – Adam

While Adam attends a large private university and prides himself on his dedication to school work, Naiyah attends a Community College and has recently started to take some courses online, and she is pleased with the change because it affords her more flexibility and autonomy, and she can better manage the anxiety that she often experienced when attending class in person.

> "I think I like online classes better because they're basically self-paced and you don't have to get up at a certain time to go to class. 'Cuz if I went in person, class starts at, like, 9 in the morning, but if I have that same class as an online class, I could probably do it, like, at 3 or any time during the week. I don't even have to go that same say. One week I could go to class on Wednesday, then the next week I could probably go on Friday. You can make your own schedule, and that's a big benefit." – Naiyah

In addition to capturing descriptions of positive experiences engaging in school, this focused code also includes experiences of having difficulty with engagement and motivation due to symptoms.

> "It's hard to be motivated when you're depressed. It's hard to concentrate. It's hard to feel like it means anything." – Ava

> "That's really what has impacted my academics the most – just the lack of motivation sometimes to do things. Yeah." – Bella

***High Hopes for College.*** While IT'LL BE BETTER IN COLLEGE, above, expressed the study participants' optimism about college being "better" than high school, this focused code captures the dimension of THE (PATIENT) STUDENT that anticipates or aspires to go to college. Max epitomizes this focused code with his comment, "I always knew I'd go to college."

***Being a Good Student.***

"I know that I'm smart and I take pride in being a good student." – Bella

Many of the interviewees expressed identifying as a "good student," or endeavoring to be one. Nearly all of them expressed a desire to do extremely well in school academically and, indeed, many of them are stellar students with high grade point averages.

***[School as Motivator.]*** **This focused code is also part of FINDING PURPOSE, above.**

This focused code captures how certain educational activities or goals motivate study participants to continue to pursue higher education despite mental health challenges.

> "My education definitely keeps me going. It's something that you just have to do. And that's really great when you're depressed and you don't know what to do. When you have something that is progressing towards this goal and keeping in

> mind that this is a means to an end, like, 'One day I'm gonna' be self-sufficient and making money." – Ava

Here, Ava describes persisting in college despite multiple medical leaves because it was her primary purpose. Education and career development are the means to the dual ends of (1) personal fulfillment through a gratifying and challenging career, and (2) the capacity to support herself.

***[Lost Time.]*** **This focused code is part of TIME OUT OF SCHOOL, above, as well.**

> "I think my mom thought about me taking a year off before starting college, but it was never an option for me because then I'd be behind everyone else. All my friends would graduate from college a year earlier, it would just be weird. I didn't want that. I didn't want to have to sit and wait and feel, like, stuck, in the same position. I was ready to move forward whether I was *really* ready to or not."
>
> - Morgan

Here, Morgan expresses wanting to avoid feeling "stuck" behind her peers, thus decides against taking a year off before beginning college. Like many of the study participants, she describes desperately wanting to avoid a nonlinear or prolonged path through college.

**LEARNING TO LIVE**

This theme includes descriptions of practical strategies for simultaneously managing one's mental health, academic responsibilities in college, and other life commitments. The theme is closely linked to the concept if "recovery" in the literature. Here, recovery is conceived as a *process* and not merely an outcome; it consists of progress and setbacks and is much more than the simple absence of symptoms. It involves "a redefinition of the self, the emergence of hope and optimism, empowerment, and the establishment of meaningful relationships" (Resnick, Rosenheck, & Lehman, 2004). Recovery reintroduces ideas of "future" and "aspiration" and is a process in which

people are able to live, work, learn, and participate fully in their communities; it is the ability of a person to live a fulfilling and productive life while they adjust to a disability that is only one of the many characteristics that define their existence (Corrigan et al., 2012, p. 170).

This theme also includes recognizing that one's mental illness or related symptoms may not entirely go away, and that recovery is a process. The theme also captures acknowledging one's mental health challenges, but not being defined by them, which is essential for thriving in college.

***Striking a Healthy Balance.*** This focused code conveys intentionally making changes to things like sleep, nutrition, and drug and alcohol use, etc., in order to better manage or improved one's mental health.

> "I feel like as much as accommodations can help people and it's good to ask for those, it's up to you to try to even though you have these problems to try to move past those and that's why I had to make so many changes to my own schedule and my own habits and relationships. I realized that I had to make very big changes. I even stopped drinking entirely because even though I never noticed any kind of changes in me from drinking there is a possibility that that might happen because statistically, drinking affects people's moods in the long run, so I stopped doing that, too." – Lily

***My Health or My Homework?*** This focused code is conceptually linked to *Striking a Healthy Balance*, above, but it is distinct in that it indicates interviewees' attitudes and/or behaviors related to negotiating mental health, wellness, and treatment(s) within the context of meeting the academic demands of college.

> "I think the hardest thing I've had to deal with in regards to my mental health issues since I've been in college is with my medication because, in addition to an anti-depressant, I also take anti-psychotics – Seroquel. And the little tranquilizer type sedative that's in that – that makes me tired for a full eight hours. And there is no time in college for eight hours of sleep!....More often than I should, I just

skip my medicine so that I can stay up late studying and then get up early the next day for class. It's like – my health or my homework?" – Morgan

***More Than My Diagnosis.*** *More Than My Diagnosis* captures comments like the ones below, where interviewees express identities shaped in part by their psychiatric disabilities, but not solely defined by them.

"I'm more than my diagnosis" - Bella

**"**I don't like to look at [my diagnosis] as it defining me; I like to look at it as a *part* of me." – Kathryn

***Learning to Live.*** This focused code captures insights about the fact that mental illnesses or related symptoms may not disappear entirely, and that recovery is a process.

"I always tended to think of myself as a person with depression, but I've come to think of it more as that's just one part of me. It's not who I am….Back when I was really suicidal, I thought of recovery more as being completely cured of depression. But since I've had the ECT and it didn't really take away my depression entirely, I think of it more now as learning how to cope with it and deal with it. Learning to live with depression, versus having it completely cured." - Max

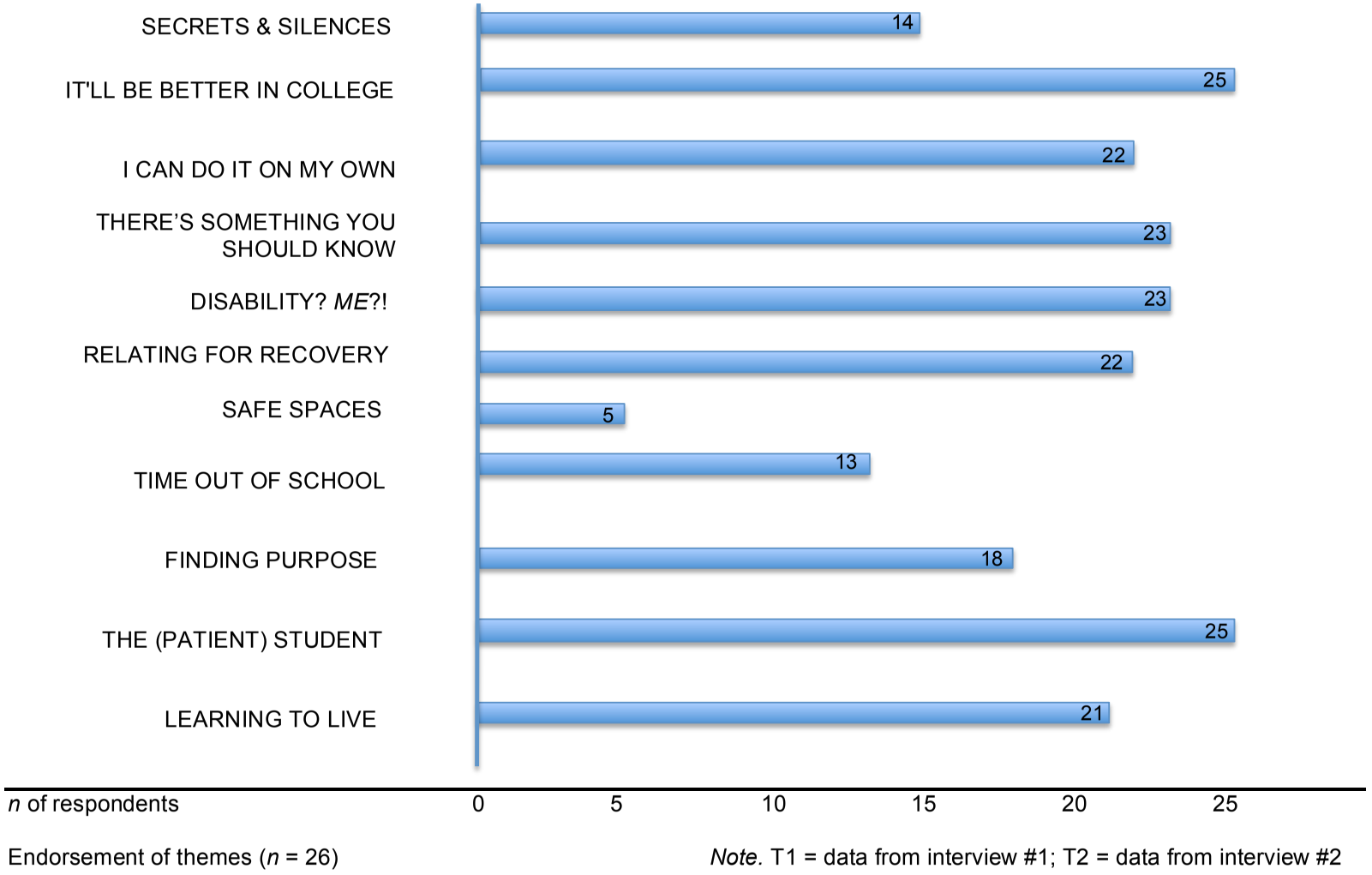
This code also expressed insights and strategies for managing one's psychiatric disability and one's education in mutually beneficial ways. For example, Naiyah learns to "do college" in her own way and in her own time by deciding to complete her coursework online because going in-person to class causes her overwhelming anxiety. She found that she couldn't express herself in class verbally, or even approach the professor to ask questions of him or her afterwards, in a way that felt comfortable or, she felt, was heard and understood. She prefers to express herself in writing, she say, and feels that she is able to "participate" in class online in a way that is more beneficial for her learning, and also allows for better interactions with her classmates – albeit mediated through technology.

***Wherever You Go, There You Are.*** Several of the study participants had unexpected psychiatric hospitalizations or took medical leaves during college due to recurring symptoms. This experience of "the problems coming back" or the acknowledgement that they "never really went away" causes certain participants to reach a point of understanding that managing their mental health is, in fact, a long-term challenge and is not necessarily fixed to one point in time or one location.

> "I always just equated college with happiness. I thought if I got there, I would be really happy, and it would be a great and wonderful place. When I got here, don't get me wrong, it was everything I thought it would be, but it doesn't necessarily change how you're feeling on the inside….Now I know that you can't just run from your problems; there's a point when you have to face them." – Max

Max's insight leads him to develop strategies for coping with his mental health challenges both within college and beyond it in order to achieve his educational goals. This focused code *Wherever You Go, There You Are*, then, captures students' acknowledgement that they need to actively engage in their own recoveries, which is a necessary step toward *Constructing a Recovery Identity* (see the key theoretical construct in Figure 5.2, below) beneficial for both health and learning.

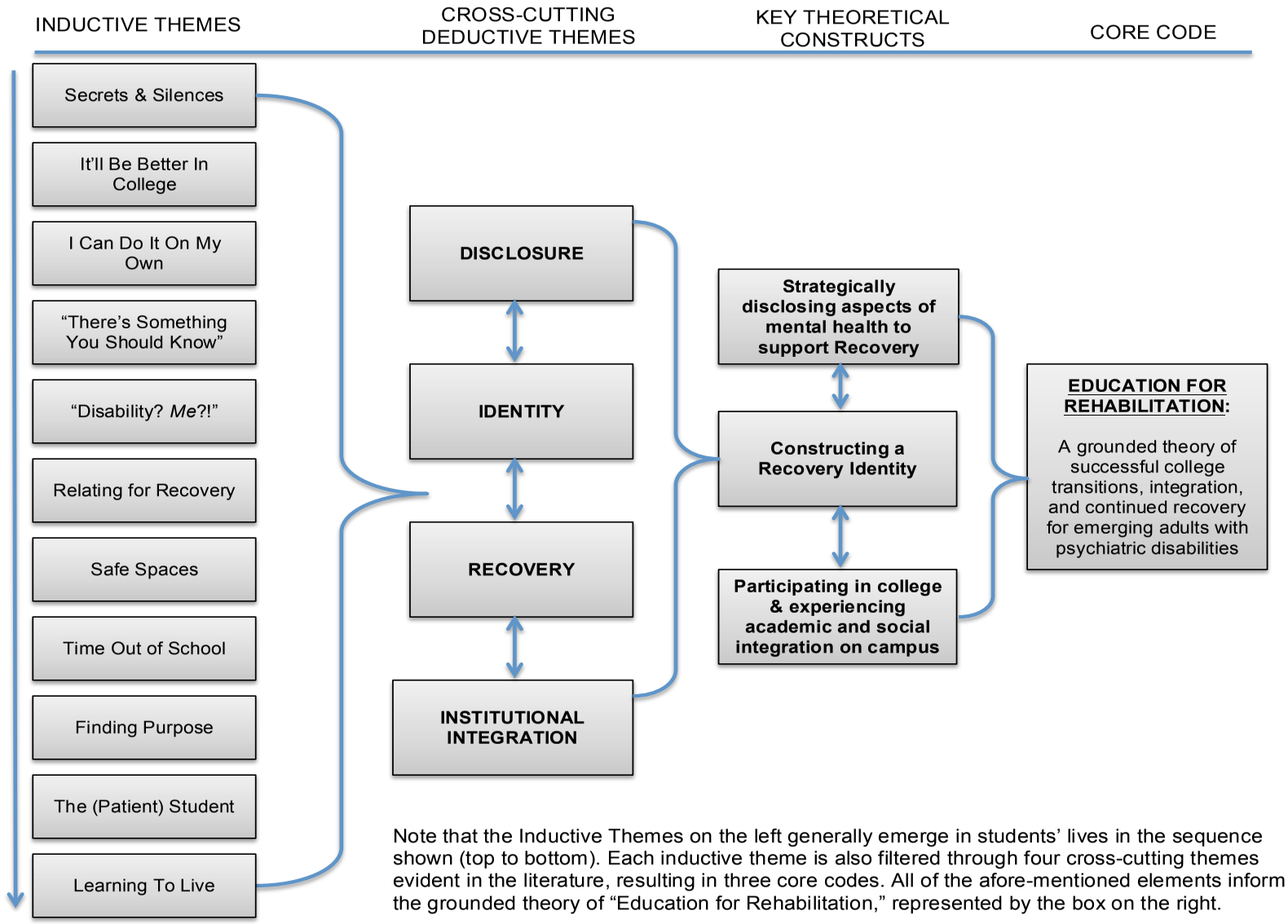
**Figure 5.1** Frequency of themes mentioned by 26 interview participants (in *either* T1 or T2 intv)




Endorsement of themes (*n* = 26)

*Note.* T1 = data from interview #1; T2 = data from interview #2

**Figure 5.2** Grounded theory of Education for Rehabilitation




Note that the Inductive Themes on the left generally emerge in students' lives in the sequence shown (top to bottom). Each inductive theme is also filtered through four cross-cutting themes evident in the literature, resulting in three core codes. All of the afore-mentioned elements inform the grounded theory of "Education for Rehabilitation," represented by the box on the right.

**Four Cross-cutting Deductive Themes**

I had the following two broad constructs in mind when initially designing this study: DISCLOSURE and COLLEGE INTEGRATION. Because I specifically asked questions in my conversations with participants related to these constructs, it is not surprising that they, are, indeed, reflected in the data. What I did not anticipate, however, is that these two constructs would be so pervasive. Every one of the eleven fore-mentioned themes is related somehow to disclosure and integration in college. In addition, two other themes that I had not identified at the outset became evident after the first wave of interviews: IDENTITY and RECOVERY. I was not surprised that Identity arose as a key feature in many of the participants' narratives, as identity development is considered a primary "task" in adolescence and continues throughout emerging adulthood (Erikson, 1968; Arnett, 2000). What I did not anticipate prior to conducting the interviews is that the theme of RECOVERY would emerge so clearly, as well. Although I had included literature from the Psychiatric Rehabilitation and Recovery movements in my initial conceptual framework, I had thought that this was more a way to foreground my own belief in the possibility of recovery, and my commitment to emphasizing the study participants' strengths and resilience. I did not expect that the theme would arise so plainly across nearly all of the students' stories. Many of the students used the word "recovery" in reflecting on their experiences, but far more simply shared stories that highlighted elements of recovery from mental illness already evidenced in the empirical literature: the importance of social supports, of finding meaning and "purpose," of reframing one's "illness identity" ("I didn't think I'd ever get better" – Bella describing a long hospitalization after a suicide attempt in high school) into a recovery identity ("I'm

more than my diagnosis. It's a big part of me, but it doesn't define me" – Bella describing how she understands her mental health at the end of her Freshman year in college.)

All four of these deductive themes, in fact (DISCLOSURE, INTEGRATION, IDENTITY, and RECOVERY) interact with the eleven grounded themes described above. The grounded theory of "Education for Rehabilitation" presented in Figure 5.4 depicts the process of college transition, integration, and continued recovery for emerging adults with psychiatric disabilities. Note that this theory operates at the level of the student, representing what an individual may experience in his or her journey to and through college.

The inductive themes have a general (though flexible) sequence, with certain themes more typical in high school and others emerging as students face particular turning points in college. Many of the themes evolve in students' lives simultaneously, as well. In addition, all eleven inductive themes are filtered through the four cross-cutting themes of DISCLOSURE, IDENTITY, RECOVERY and INSTITUTIONAL INTEGRATION. As students move through this process three phenomena emerge as essential elements for a student's successful college transition; these three key theoretical constructs, are: (1) strategically disclosing aspects of one's mental health to support recovery; (2) constructing a recovery identity; and (3) participating in college and experiencing academic and social integration on campus.

**Three Key Theoretical Constructs**

**(1) Strategically Disclosing Aspects of Mental Health to Support Recovery.**

This theoretical construct merges elements from the four deductive themes, above, as well as the following five inductive themes: SECRETS & SILENCES, THERE'S SOMETHING YOU SHOULD KNOW, "DISABILITY? ME?!," RELATING FOR RECOVERY, and TIME OUT OF SCHOOL. Taken together, these themes illustrate the process of employing "strategic disclosure" of certain aspects of one's psychiatric disability in educational contexts in order to support, maintain, and/or promote one's recovery while a college student. This promotion of recovery through disclosure may take the form of self-identifying as a student with a disability at campus Student Disability Services, or it may manifest in telling select trusted peers about one's health history. Although SECRETS AND SILENCES were common in high school for the majority of the interviewees, all but one of them have intentionally and voluntarily disclosed to at least one person on campus since beginning college.

**(2) Constructing a Recovery Identity.**

This theoretical construct merges elements from the four deductive themes, above, as well as the following six inductive themes: "DISABILITY? *ME*?!," RELATING FOR RECOVERY, TIME OUT OF SCHOOL, FINDING PURPOSE, THE (PATIENT) STUDENT, and LEARNING TO LIVE. When combined, the themes illustrate the process of moving through an "illness identity" (where one's psychiatric disability is the most salient part of one's identity) and toward the construction of a new, and more holistic "recovery identity," wherein one's sense of self includes one's diagnosis, but is not restricted by it. Identifying as someone living with a mental illness and actively

engaging in one's recovery, forging supportive and pro-social relationships, seeking meaning and purpose in life, managing one's health while pursuing educational goals, and – ultimately – learning to live with a mental illness while also thriving are all part of this process of identity construction.

**(3) Participating in College and Experiencing Academic and Social Integration on Campus.**

This theoretical construct merges elements from the four deductive themes, above, as well as the following ten inductive themes (every theme but SECRETS & SILENCES): IT'LL BE BETTER IN COLLEGE, I CAN DO IT ON MY OWN, THERE'S SOMETHING YOU SHOULD KNOW, "DISABILITY? *ME*?!," RELATING FOR RECOVERY, SAFE SPACES, TIME OUT OF SCHOOL, FINDING PURPOSE, THE (PATIENT) STUDENT, and LEARNING TO LIVE. Taken together, the themes depict the process and experience of integration in college, both academically and socially. High hopes for college and optimism about the experience combine with a sense of increased autonomy and self-determination once in college. Next, negotiating disclosures on campus and forging relationships with peers in safe literal and figurative spaces proceeds. For some, time away from school to focus on health and recovery is necessary, while for most a burgeoning sense of purpose emerges – often tied to being a student. If the study participants navigate this process successfully, they evolve past identifying simply as "patients" and become patient *students* who learn that to live optimally, they must simultaneously manage health and education in an integrated way. Ultimately, successful academic and social participation in college allows students to integrate into the campus communities in which they live and learn.

**Core Code: Education for Rehabilitation**

When the above three key theoretical constructs are considered together, a Core Code emerges that encapsulates the entire grounded theory presented in the qualitative strand of this study: EDUCATION FOR REHABILITATION. This core code represents the process of successful college transitions, integration, and continued recovery for emerging adult college students with psychiatric disabilities. It is important to note that the code is meant not just as a descriptor, but as a call to action and as a conscious nod to Freire's concept of "education for liberation." Before describing it in its entirety, below, it is necessary to define "rehabilitation" in the way that it is operationalized here. According to the Boston University Center for Psychiatric Rehabilitation, the mission of the field of psychiatric rehabilitation

> is to help persons with long-term psychiatric disabilities increase their functioning so that they are successful and satisfied in the environments of their choice, with the least amount of ongoing professional intervention (Farka & Anthony, 1989). The major methods by which this mission is accomplished involve either developing the specific skills the person needs to function effectively and/or developing the supports needed to strengthen the person's present levels of functioning…The term *rehabilitation* reflects the focus of the field on improved abilities within a specific environment. In that respect, the field of psychiatric rehabilitation shares a common philosophy with the field of physical rehabilitation" (Anthony et al., 2002, pp. 2-3).

Education and Rehabilitation are tightly interwoven in the narratives and lives of the study participants. Indeed, most of them conceive of education as a means through which to increase their own functioning and to lay the foundation for future personal and professional fulfillment. Many of the students describe developing their own coping strategies and skills to navigate higher education effectively, and to maintain and strengthen their mental health while there. They are, in essence, rehabilitating themselves

within the specific environment of higher education, and they consider this environment essential to their ongoing recovery journeys. Recovery here includes establishing new roles and purpose in their daily lives, and forging connections and positive relationships with peers and mentors through active engagement in school.

EDUCATION FOR REHABILITATION operates at the individual student level, but in order for this grounded theory to be useful in applied settings (e.g. to inform practice, policy, and/or interventions), I believe that it can – and should – be expanded beyond the individual level to include the "institutional level" and the dynamic interactions between students and schools/universities over time in the service of both education and rehabilitation. Just as Disability Studies in Education conceives of "disability" as a social construction and not inherent to an individual (Valle & Conner, 2011), it is necessary to consider how educational institutions themselves co-construct "psychiatric disability" and influence the experiences and trajectories of students, while these same students in turn negotiate and shape campus environments. Understanding a student's individual process of "education for rehabilitation" ultimately informs how institutions of higher education can innovate to better support these students, leading to a call for "Rehabilitating Education" more broadly (see Chapter Eight, Discussion).

**Chapter Five Summary**

In this chapter I introduced the eleven inductive themes that emerged from all of the qualitative data, then described each of the focused codes comprising these themes. Next, I introduced four cross-cutting deductive themes (disclosure, identity, recovery, and institutional integration), then shared the three key theoretical constructs that emerged from careful analysis of the interaction of the inductive and deductive themes. After

describing and defining these constructs, the chapter culminates with a Core Code: "Education for Rehabilitation."

# Chapter 6

# QUANTITATIVE RESULTS

## Chapter Overview

As a reminder, the purpose of this study is to explore and describe the experiences of emerging adults with psychiatric disabilities as they plan for and transition to and through higher education. A secondary purpose is to investigate whether and how decisions related to psychiatric disability disclosure shape students' social and academic integration on college campuses. And, finally, a tertiary purpose is to examine possible relationships among disclosure, institutional integration, and students' sense of recovery in educational contexts. With this in mind, this chapter presents quantitative results from the online survey. Frequencies and descriptive statistics are presented for relevant items. In addition, tables with correlations assess associations between certain variables; paired samples t-tests evaluate change over time (from high school to college) on the same variables; and linear regression is utilized to investigate predictive relationships among select variables. The structure of this chapter is organized to answer the following research questions in order:

## Revisiting the Initial Research Questions

RQ #1: What is the process of preparation for and transition to and through higher education for young adults with psychiatric disabilities (PDs)?

Sub-questions:

1.a How do adolescent high school students with PDs prepare for college?

1.b What are these students' experiences of social and academic integration in college over time?

RQ #2: To whom and why do youth and emerging adults (EAs) with PDs make mental health disclosures in educational contexts?

Sub-questions:

2.a. Do these disclosures change as students move from high school to college?

2.b. What are others' reactions to students' mental health disclosures in college?

RQ #3: What are the relationships among disclosure, institutional integration, and recovery for EA college students w/ PDs?

Sub-questions:

3.a. Does psychiatric disability disclosure in high school predict disclosure in college?

3.b. Does psychiatric disability disclosure to college peers predict disclosure to college faculty?

3.c. Does psychiatric disability disclosure to college peers predict use of campus-based counseling or psychological services?

3.d. Does psychiatric disability disclosure to college peers predict use of Student Disability Services on campus?

3.e. Is psychiatric disability disclosure in college associated with institutional integration (IIS)? And IIS subscales?

3.f. Is psychiatric disability disclosure in college associated with subjective experiences of recovery (RAS) ? And RAS subscales?

3.g. Is institutional integration associated with recovery?

This chapter only presents survey findings that are relevant to answering the above research questions; additional data exists from the survey that can be analyzed in future work.

In the chapter that follows this one (Chapter 7), I integrate key quantitative findings with related qualitative themes and analyze both datasets together. That said, the majority of the current chapter consists of statistical results, with some additional text explanation and analysis where necessary.

**Survey Respondent demographics**

**Gender, race and ethnicity.** A total of seventy-eight college students completed the online survey, with 68 female respondents (88% of the sample), 9 male respondents (11.5%), and 1 respondent (1.3%) identifying gender as "other." Regarding race and ethnicity, 48 of the survey respondents identify as Caucasian (61.5%), while 9 are Asian (11.5%), 7 are Latino/a or Hispanic (9%), an additional 7 identify as multi-racial, 4 identify as African-American or Black (5.1%), 2 selected "other" for this item, and 1 respondent is Native American or Alaskan Native (1.3%).

**Diagnoses.** Regarding their psychiatric disabilities, 72 (92.3%) survey respondents reported having an anxiety disorder, while 60 (76.9%) reported a mood disorder. In addition, 21 respondents (26.9%) reported an eating disorder, 2 (2.6%) reported a psychotic disorder, and 29 selected "other" for this item. It is noteworthy that 59 of the respondents (75.6% of the entire sample) report two or more diagnoses. High rates of comorbidity are common in the general population (Kessler, Chiu, Demler, & Walters, 2005b) and this is true for this study's sample, as well. (For further details on frequencies

for specific diagnoses, see Table 6.3). The mean number of diagnoses per respondent is 2.35, with anxiety and mood disorders the most common dual diagnoses.

**Secondary schools attended.** Regarding the types of secondary schools that survey respondents attended, the vast majority (56, 71.8%) attended U.S. public high schools, while the remainder attended either private day schools 26 (33.3%), religiously-affiliated schools, therapeutic schools for youth with emotional disturbance, or were home-schooled (13, 16.7%). The 78 respondents attended a total of 95 high schools, which is why the total percentages for type of secondary school attended sum to more than 100 percent. Some students moved during high school, while others attended a variety of different types of schools. (For example, Jess, one of the interviewees, attended four different high schools: two conventional public schools in her district, one private school, and a public therapeutic school at different points during her high school years. These various enrollments were separated by several psychiatric hospitalizations for her bipolar disorder).

**Special Education in high school.** Only 12 (15.4%) of the survey respondents were identified as having a disability in high school and received Special Education services and IEPs. It is remarkable that so few of the respondents received academic accommodations or any other services in high school, given that 18 (23.1%) of them reported hospitalizations and 14 (17.9%) reported significant absences due to symptoms during middle and/or high school. (See Table 6.5.3 for details on hospitalizations and school absences.)

**Academic achievement in high school.** The average high school grade point average for the respondents is 3.75 on a 4-point scale, showing that these students are

above the norm academically. Their academic achievement in secondary school despite their mental health challenges is impressive, and likely has to do with the fact that this sample of students – unlike the majority of youth with emotional disturbance – did successfully graduate from high school and go on to attend college.

**Colleges attended.** There are 37 different colleges and universities represented among the 78 survey respondents, and these institutions are spread across 31 states. Seventy-five of the respondents (96.2%) attend 4-year institutions, while the remaining 3 (3.8%) attend 2-year community colleges. And regarding what specific types of 4-year institutions the respondents attend, 32 of them (41%) attend public research universities, 24 (30.8%) attend private research universities, 15 (19.2%) attend liberal arts colleges, and the remaining 4 (5.1%) attend regional universities.

**Age and year in college.** The respondents range in age from 18 to 25, and the mean age is 20.74. Relatedly, the majority of respondents are in their third or fourth year of a 4-year program at the time of survey completion. Eleven students (14.1%) are Freshman, 16 (20.5%) are Sophomores, 20 (25.6%) are Juniors, and 24 (30.8%) are Seniors. The remaining 7 (9.0%) students are in the $5^{th}$ or $6^{th}$ year of a 4-year program. Their mean cumulative college GPA is 3.36.

Table 6.1
*All Survey Respondents - Demographics Overview*

| | n | % | mean |
|---|---|---|---|
| Age | | | |
| all participants are age 18-25 | 78 | 100 | 20.74 |
| Sex | | | |
| Female | 68 | 88.0 | |
| Male | 9 | 11.5 | |
| Other | 1 | 1.3 | |
| Race | | | |
| Caucasian | 48 | 61.5 | |
| Asian | 9 | 11.5 | |
| Latino/a or Hispanic | 7 | 9.0 | |
| Multi-racial | 7 | 9.0 | |
| African-American or Black | 4 | 5.1 | |
| Other | 2 | 2.6 | |
| Native Am. or Alaskan Native | 1 | 1.3 | |
| General type of Psychiatric Disabilities[1] | | | |
| Anxiety disorder | 72 | 92.3 | |
| Mood disorder | 60 | 76.9 | |
| Eating Disorder | 21 | 26.9 | |
| Psychotic disorder | 2 | 2.6 | |
| Other[2] | 28 | 35.9 | |
| Two or more diagnoses[3] | 59 | 75.6 | |
| Type of High School attended[4] | | | |
| Public | 56 | 71.8 | |
| Private | 26 | 33.3 | |
| Religious | 7 | 9.0 | |
| Therapeutic | 3 | 3.8 | |
| Home-schooled; Cyber school | 3 | 3.8 | |
| Identified with disability & had IEP in HS | 12 | 15.4 | |
| High School cumulative GPA (4 point scale) | | | 3.75 |
| Type of college attending[5] | | | |
| 4-yr institution | 75 | 96.2 | |
| 2-yr college institution | 3 | 3.8 | |
| Private research univ | 24 | 30.8 | |
| Public research univ | 32 | 41.0 | |
| Private Liberal Arts college | 15 | 19.2 | |
| Public regional univ | 4 | 5.1 | |
| Public Community college | 3 | 3.8 | |
| Year in college | | | |
| 1st yr of 2-yr program | 2 | 2.6 | |
| 2nd yr of 2-yr program | 2 | 2.6 | |
| 1st yr of 4-yr program | 9 | 11.5 | |
| 2nd yr of 4-yr program | 14 | 17.9 | |
| 3rd yr of 4-yr program | 20 | 25.6 | |
| 4th yr of 4-yr program | 24 | 30.8 | |
| 5th or 6TH yr of 4-yr program | 7 | 9.0 | |
| College cumulative GPA (4-point scale) | | | 3.36 |

N = 78 *Note*. These respondents include the 22 interview participants who also completed the survey, as well as 56 anonymous respondents.

[1] For more details on survey respondents' specific diagnoses, please see Table 6.3

[2] "Other" diagnoses include: ADHD (14); Borderline Personality Disorder (6); Substance Abuse (3); (1) each for Adjustment, Conversion, Depersonalization, and Dissociative Identity disorders; and Dermatillomania (1)

[3] 19 respondents (24.2%) have only 1 diagnosis, while 27 (34.6%) have 2, and 32 (41%) have 3 or more.

[4] A total of 95 high schools were attended by the 78 respondents

[5] All respondents attend higher ed. full-time with exception of one of the three community college students

Table 6.2
*Interview Participants who also completed survey - Demographics*

| | n | % | mean |
|---|---|---|---|
| Age | | | |
| all participants are age 18-25 | 22 | 100.0 | 20.9 yrs |
| Sex | | | |
| Female | 19 | 86.4 | |
| Male | 3 | 13.6 | |
| Race | | | |
| Caucasian | 13 | 59.1 | |
| African-American or Black | 3 | 13.6 | |
| Latino/a or Hispanic | 1 | 4.5 | |
| Multi-racial | 3 | 13.6 | |
| Other | 2 | 9.1 | |
| General type of Psychiatric Disabilities[1] | | | |
| Mood disorder | 18 | 81.2 | |
| Anxiety disorder | 13 | 59.1 | |
| Psychotic disorder | 1 | 4.5 | |
| Eating Disorder | 3 | 13.6 | |
| Other[2] | 3 | 13.6 | |
| Two or more diagnoses | 12 | 54.5 | |
| Type of High School attended[3] | | | |
| Public | 14 | 63.6 | |
| Private | 9 | 40.9 | |
| Therapeutic | 1 | 4.5 | |
| Religious | 1 | 4.5 | |
| Other | 1 | 4.5 | |
| Identified with disability & had IEP in HS | 2 | 9.1 | |
| High School cumulative GPA (4 point scale)[4] | | | 3.45 |
| Type of college attending[5] | | | |
| Attending 4-yr college | 19 | 86.4 | |
| Attending 2-yr college | 2 | 13.6 | |
| Private research univ[6a] | 10 | 45.5 | |
| Public research univ | 6 | 27.3 | |
| Private Liberal Arts college[6b] | 3 | 13.6 | |
| Public regional univ | 1 | 4.5 | |
| Public Community college | 2 | 9.1 | |
| Year in College | | | |
| 1st yr of a 2-yr program | 2 | 9.1 | |
| 1st yr of a 4-yr program | 8 | 36.4 | |
| 2nd yr of a 4-yr program | 5 | 22.7 | |
| 3rd yr of a 4-yr program | 5 | 22.7 | |
| 4th yr of a 4-yr program | 1 | 4.5 | |
| 5th yr of a 4-yr program | 1 | 4.5 | |
| College cumulative GPA (4-point scale) | | | 3.27 |

N = 22
[1] Diagnostic percentages sum to over 100%; indicates high rate of comorbidity. Ten respondents (45.4%) have 1 diagnosis, while seven (31.8%) have 2 diagnoses, and five (22.7%) have 3 or more.
[2] "Other" MH conditions include: Self-harm (1); ADHD (1); Conversion Disorder (1)
[3] Number of high schools attended totals 26 for the 22 interviewees because some students attended >1 school
[4] Ten of the 22 interviewees who also completed survey had cumulative high school GPA of ≥ 4.0
[5] All are attending college full-time
[6a, 6b] Five of 13 interviewees who also completed survey attend private institutions ranked "most selective" (admit ≤15% of applicants)

Table 6.3

*Survey Respondent Current Psychiatric Diagnoses - Details*

| Disorder type | # participants w/ Dx | % of all Dxs *n* = 183 | % of total sample w/ this Dx (*n* = 78) |
|---|---|---|---|
| Anxiety Disorder | 72 | 39.3 | 92.3 |
| GAD | 40 | 21.9 | 51.3 |
| OCD | 12 | 6.6 | 15.4 |
| Panic Disorder | 9 | 3.3 | 11.5 |
| PTSD | 7 | 3.8 | 9.0 |
| Social Anxiety | 4 | 2.2 | 5.1 |
| Mood Disorders | 60 | 32.8 | 77.0 |
| Major Depression | 44 | 24.0 | 56.4 |
| Bipolar Disorder | 16 | 8.7 | 20.5 |
| Eating Disorders | 21 | 11.5 | 26.9 |
| EDNOS | 10 | 5.5 | 12.8 |
| Bulimia | 7 | 3.8 | 9.0 |
| Anorexia | 4 | 2.2 | 5.1 |
| ADHD | 14 | 7.7 | 17.9 |
| Borderline Personality Dis. | 6 | 3.3 | 7.7 |
| Substance Abuse | 3 | 1.6 | 3.8 |
| Other | 5 | 2.7 | 6.4 |
| Adjustment Dis | 1 | 0.5 | 1.3 |
| Conversion Dis | 1 | 0.5 | 1.3 |
| Depersonalization Dis | 1 | 0.5 | 1.3 |
| Dermatillomania | 1 | 0.5 | 1.3 |
| Dissoc. Identity Dis | 1 | 0.5 | 1.3 |
| Psychotic Disorders | 2 | 1.1 | 2.6 |
| Schizophrenia | 1 | 0.5 | 1.3 |
| PDNOS | 1 | 0.5 | 1.3 |

N = 78

*Note.* The percentages in the far right column sum to well over 100% due to the high rate of comorbidity among the survey respondents.

There are 20 separate types of diagnoses reported by respondents, separated into the eight "type" categories in the far left column, above. In addition, there are 183 separate diagnoses endorsed across the 78 survey respondents, making the mean number of diagnoses per respondent 2.35.

19 of the respondents (24.2%) have 1 diagnosis, 27 (34.6%) have 2 diagnoses, and 32 (41%) have 3 or more diagnoses.

Table 6.4.1

*Special Education in High School, Academics, & School Activities*

| | n | % total sample (n = 78) |
|---|---|---|
| **Academics** | | |
| High School cumulative GPA (4 point scale)[2] | | |
| Mean = 3.75 | | |
| Range = 2.0 to 5.0 | | |
| Had Individualized Education Program (IEP) at some point during HS | 12 | 15.4 |
| If had IEP, participated in "postsecondary transition planning" mtgs | 5 | 41.7 |
| Discussed college planning in these meetings | 4 | 33.3 |
| Spent majority of high school classes w/ peers who did *not* have a MI or "emotional disturbance" | 62 | 79.5 |
| Graduated with HS diploma in 4yrs | 76 | 97.4 |
| Graduated with HS diploma in 5 yrs | 1 | 1.3 |
| Graduated with GED | 1 | 1.3 |
| **School activities** | | |
| Extracurricular participation | 72 | 92.3 |
| Sports | 34 | 43.6 |
| Band, orchestra, music | 32 | 41.0 |
| Drama, theater, school plays | 28 | 35.9 |
| Student Government | 21 | 26.9 |
| Yearbook | 6 | 7.7 |

*Note*. N = 78

[1]A total of 95 high schools were attended by the 78 respondents

[2]41 of the 78 survey respondents reported a 4.0 or higher HS GPA. 31 students (39.7%) had 4.0 HS GPA; 6 students (7.7%) had a 4.5 HS GPA; and 4 students (5.1%) had a 5.0 HS GPA.

## Addressing RQ #1 Quantitatively: Preparation for and Transitions to College

**Social Inclusion in High School.** As described above, the vast majority of study participants attended conventional (i.e. non-therapeutic) high schools. In addition, they were, on average, very engaged with their schools as well as their larger communities. Seventy-two (92.3%) participated in at least one extra-curricular activity in high school, with sports being the most popular. Respondents also engaged in band, theater, student government, and yearbook. In addition, more than half of respondents (55%) worked for pay and/or volunteered in their communities while in high school.

Table 6.4.2

*Community Engagement & Social Life in High School*

| | n | % who worked/ volunteered in HS | % total sample (n = 78) |
|---|---|---|---|
| **Community Engagement** | | | |
| Had a paid job while in high school | 43 | 100.0 | 55.1 |
| 1-10 hrs/week | 14 | 32.6 | 17.9 |
| 11-20 hrs/week, | 24 | 55.8 | 30.8 |
| 21-30 hrs/week | 5 | 11.6 | 6.4 |
| Did volunteer work while in high school | 57 | 100.0 | 73.1 |
| 1-5 hrs/week | 42 | 73.7 | 53.8 |
| 6-10 hrs/week | 15 | 26.3 | 19.2 |
| **Social Life and supportive relationships** | | % who had at least one good friend in HS (n = 54) | % total sample (n = 78) |
| "I had at least one good friend in HS that I trusted and could talk to if I needed support." | 54 | 100.0 | 69.2 |
| "This friend also had a mental illness." | 22 | 40.7 | 28.2 |
| "I had at least one adult in my life, outside my immediate family, that I trusted and could talk to if I needed support." | 51 | 65.4 | |
| "While I was in high school, I was satisfied with my social life." | 28 | 35.9 | |

Regarding how they perceived their social lives in high school, the majority of students (69.2%) reported that they had at least one good, trusted friend with whom they could talk if they needed support. Interestingly, for 22 of these respondents (40.7% of those with a trusted friend), this friend also has a mental illness. In addition to peers, fifty-one respondents (65.4%) reported having at least one adult in their lives, outside of their immediate families, that they trusted and could turn to for support. Despite these supportive friends and adults, however, only 28 (35.9%) of the respondents reported feeling "satisfied" with their social lives in high school. This means that approximately 64% of the respondents were not satisfied with their social lives in high school. In the absence of a comparison group of peers without psychiatric disabilities, it is difficult to know if this statistic is typical for adolescents in general, or whether it is higher for this sample and could potentially have to do with stigma or isolation related to their mental health disorders.

Also interesting to note is that there are significant differences in perceptions of social life between high school and college. (See Figures 6.1.1 and 6.1.2, and Table 6.4.3, below). Scores for having "one good, trusted friend," and for being "satisfied" with one's social life in general are both significantly higher in college.

Bar Charts Depicting Social Life in High School vs. College

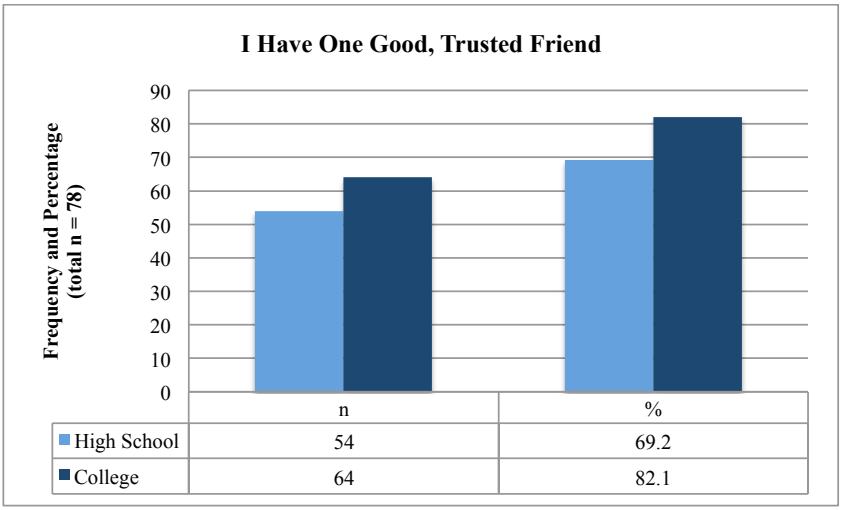



*Fig. 6.1.1* Responded "Strongly Agree" or "Agree to the prompt, "I have one good friend that I trust and can talk to if I need support." Note that the differences in satisfaction between high school and college on this item are significant, with details in Table 6.4.3.

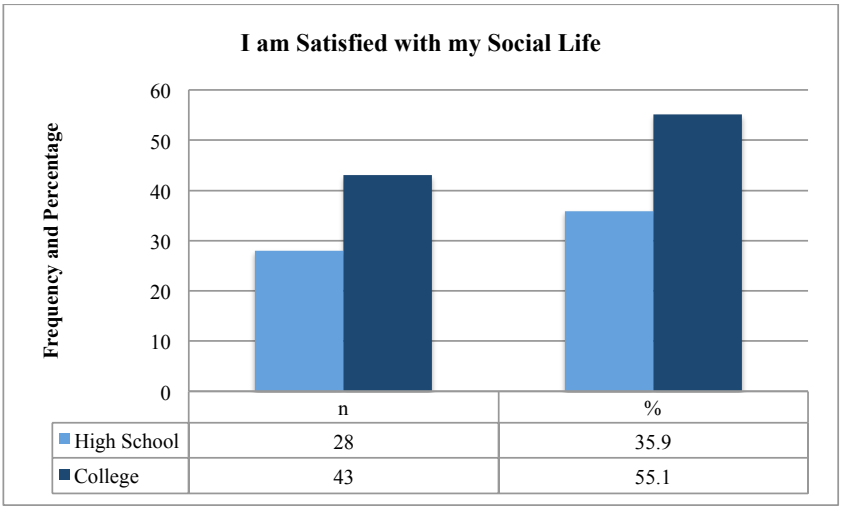



*Fig. 6.1.2* Responded "Strongly Agree" or "Agree to the prompt, "I am satisfied with my social life at school." Note that the differences in satisfaction between high school and college on this item are significant, with details in Table 6.4.3.

Table 6.4.3

*Significant Differences in Social Life between High School and College: Paired Samples t-Test*

Paired Samples Statistics

| | | Mean | N | Std. Deviation | Std. Error Mean |
|---|---|---|---|---|---|
| Pair 1 | In HS, I had at least one good friend that I trusted and could talk to if I needed support. | 3.68 | 78 | 1.222 | .138 |
| | In college, I have at least one good friend that I trust and can talk to if I need support. | 4.22 | 78 | 1.028 | .116 |
| Pair 2 | While I was in HS, I was satisfied with my social life. | 2.75 | 77 | 1.309 | .149 |
| | As a college student, I am satisfied with my social life. | 3.35 | 77 | 1.244 | .142 |

Paired Samples Correlations

| | | N | Correlation | Sig. |
|---|---|---|---|---|
| Pair 1 | In HS, I had at least one good friend I trusted and could talk to if. I needed support. & In college, I have at least one good friend that I trust and can talk to if I need support. | 78 | .191 | .094 |
| Pair 2 | While I was in HS, I was satisfied with my social life. -& As a college student, I am satisfied with my social life. | 77 | .175 | .128 |

Paired Samples Test

| | | Paired Differences | | | | | t | df | Sig, (2-tailed) |
|---|---|---|---|---|---|---|---|---|---|
| | | Mean | Std. Dev. | Std. Error Mean | 95% Confidence Interval of the Difference Lower | Upper | | | |
| Pair 1 | In HS, I had at least one good friend … - In college, I have at least one good friend… | -.538 | 1.439 | .163 | -.863 | -.214 | -3.305 | 77 | .001* |
| Pair 2 | … in HS, I was satisfied with my social life. -As a college student, I am satisfied with my social life. | -.597 | 1.640 | .187 | -.970 | -.225 | -3.196 | 76 | .002* |

*Note*. High School and College experiences of having "one good and trusted friend" are weakly and positively correlated, (r = .191), but the correlation is not significant (*p* is .094). High School and College satisfaction with one's social life are weakly and positively correlated (r = .174) but the correlation is not significant (*p* = .128),

There is a significant difference between High School and College mean scores for experiences of having at least "one good, trusted friend" ($t_{77} = 3.31$, $p < 0.001$). The average College score for having one good, trusted friend is .56 points higher than the average High School score (95% CI [.21, .86]). This is on a 5-point scale where 1 is "Strongly Disagree" and 5 is "Strongly Agree" with the statement: "In high school/college, I had at least one good friend that I trusted and could talk to if I needed support."

There is also a significant difference between High School and College mean scores for being satisfied with one's social life ($t_{77} = 3.20$, $p = .002$). The average College score for being satisfied with one's social life is .60 points higher than the average High School score (95% CI [.23, .97]). This is on a 5-point point scale where 1 is "Strongly Disagree" and 5 is "Strongly Agree" with the statement: "In high school/college, I was/am satisfied with my social life."

*p > .01

**Mental Health in Secondary School**

**Diagnosis details.** Seventy-two respondents report having an anxiety disorder (92.3% of the sample), while 60 (77%) report having a mood disorder. Two respondents (2.6%) report a psychotic disorder. In addition to these three categories of disorder (which were part of the inclusion criteria for the study), several other types of mental

health diagnoses were also reported: 21 respondents reported an eating disorder (26.9%), 14 have ADHD (17.9%), 6 report a personality disorder (7.7%), 3 (3.8%) report a substance use disorder, and an additional 5 respondents selected "other." As noted above, the percentages here sum to well over 100%, signaling the high rate of comorbidity. There are twenty separate diagnoses reported by the respondents, and these can be organized into eight categories (see table 6.3). It is noteworthy that there are a total of 183 separate diagnoses endorsed across the 78 respondents. This makes the mean number of diagnoses per respondent 2.35. Nineteen respondents (24.2%) have 1 diagnosis, 27 (34.6%) have 2 diagnoses, and 32 (41%) have 3 or more diagnoses.

**Time between symptom onset and first treatment.** Table 6.5.1, below, shows that 53 respondents (67.9%) first experienced mental health problems in elementary or middle school, while the remaining 25 (32.1%) first experienced symptoms in high school or immediately after high school. Despite the onset of symptoms in early adolescence for most respondents, the majority of respondents did not receive a diagnosis or any mental health treatment or services until mid- to late adolescence or emerging adulthood. Of the 53 who experienced symptoms in elementary or middle school, only 21 (39.6% of this sub-group) received services during this time period. Thirty-one respondents (39.7% of the entire sample) were first diagnosed and accessed treatment in high school, and 26 (33.3%) were not diagnosed or treated until *after* high school. Again, this is despite the fact that 74 of the 78 respondents (94.9%) experienced symptoms *prior* to completing high school.

There were often lengthy delays between first experiencing symptoms and finally receiving mental health treatment. For this sample, the average length of time between

the respondent first experiencing a mental health problem and receiving a diagnosis from a mental health professional is 4.4 years, but this waiting period ranges from less than 1 year to nearly 15 years, with a modal waiting time of 6 years.

Table 6.5.1

*Secondary School Mental Health – Disorders & First Treatment*

| | n | % (n = 78) | mean | range |
|---|---|---|---|---|
| **Type of Mental health disorder**[1] | | | | |
| Anxiety | 72 | 92.3 | | |
| Mood | 60 | 77.0 | | |
| Eating disorder | 21 | 26.9 | | |
| ADHD | 14 | 17.9 | | |
| Personality disorder | 6 | 7.7 | | |
| Other | 5 | 6.4 | | |
| Substance Abuse | 3 | 3.8 | | |
| Psychotic | 2 | 2.6 | | |
| **First experienced disorder & received treatment** | | | | |
| Grade in school when first experienced MH problem | | | | |
| 1st thru 5th grade | 23 | 29.5 | | |
| 6th and 8th grade | 30 | 38.5 | | |
| 9th thru 12th grade | 21 | 26.9 | | |
| After high school completion | 4 | 5.1 | | |
| Grade in school when first diagnosed by a MH professional | | | | |
| 1st thru 5th grade | 8 | 10.3 | | |
| 6th and 8th grade | 13 | 16.7 | | |
| 9th thru 12th grade | 31 | 39.7 | | |
| Not Dx'd until after HS | 26 | 33.3 | | |
| Length of time between first experiencing MH problem and receiving diagnosis from MH professional[2] | | | 4.4 yrs | <1 yr – 15 yrs |
| ≤1 yr | 10 | 12.8 | | |
| 2 yrs | 13 | 16.7 | | |
| 3 yrs | 11 | 14.1 | | |
| 4 yrs | 4 | 5.1 | | |
| 5 yrs | 9 | 11.5 | | |
| 6 yrs | 14 | 17.9 | | |
| 7 yrs | 5 | 6.4 | | |
| ≥ 8 yrs | 12 | 15.4 | | |

[1] See Table 6.3 for details on exact number and type of diagnoses

[2] Note that range of time between first experiencing mental health problem and receiving a diagnosis is <1 yr to 15 years. Also, a total of twelve respondents waited *8 or more yrs* between first noticing a problem and actually receiving treatment; five respondents waited *10 or more* yrs; and one respondent waited *15 years*.

**Type of treatment.** Table 6.5.2 shows that 58 respondents (74.4%) saw a mental health professional prior to beginning college, while 20 (25.6%) did not. Most respondents saw either a psychologist or a psychiatrist, or both, outside of secondary school. Some respondents also saw mental health professionals in school. Among the 32 survey respondents who consulted with a school-based mental health professional, 28 (35.9%) consulted with a school counselor at least once regarding their mental health, 14 (17.9%) consulted with a school psychologist, and 4 (5.1%) saw a school-based social worker.

Twenty-six respondents (33.3%) consulted only with mental health professionals *outside* of school, 3 (3.8%) saw *only* school-based mental health professionals, and the remaining 29 (37.2%) accessed services from *both* school- and in the community-based practitioners.

Regarding types of treatments utilized, a small majority of survey respondents (44, 56.4%) took prescription psychiatric medications while in high school, while 35 engaged in Cognitive Behavioral Therapy (CBT) for anxiety and/or depression, and 30 (44.9%) utilized various other forms of "talk" therapy with providers. Fifteen respondents (19.2%) were hospitalized at least once because of their mental illness while in secondary school, and 12 (15.4%) experienced a "partial hospitalization" where they attended treatment and therapy during the day in a hospital setting, but then went home each night. Twelve respondents (15.4%) did Dialectical Behavior Therapy for eating disorders and/or personality disorders, and five respondents (6.4%) engaged in long-term treatment in a residential facility. In addition, five respondents selected "other," signifying use of additional forms of mental health treatment prior to attending college. These treatment

modalities sum to greater than 100%, as most respondents accessed multiple forms of treatment simultaneously (e.g. medication and hospitalization, or medication and CBT).

Table 6.5.2

*Secondary School Mental Health – Type of Treatment*

| | n | % (n = 78) | % who had MH Tx prior to college (n=58) |
|---|---|---|---|
| **Mental Health treatment prior to college** | | | |
| Saw a MH prof. prior to beginning college | 58 | 74.4 | 100.0 |
| Did not see any MH profs. prior to college | 20 | 25.6 | |
| | | | |
| Type of MH profs seen prior to college | | | |
| *MH professionals outside of school*[1] | 55 | | |
| Psychologist | 46 | 59.0 | 79.3 |
| Psychiatrist | 41 | 52.6 | 70.7 |
| Clinical Social Worker | 13 | 16.7 | 22.4 |
| Primary Care Physician | 4 | 5.1 | 6.9 |
| Other | 6 | 7.7 | 10.3 |
| Nutritionist[2] | 2 | 2.6 | 3.4 |
| Licensed Professional Counselor | 1 | 1.3 | 1.7 |
| | | | |
| *MH professionals at school*[3] | 32 | | |
| School Counselor | 28 | 35.9 | 48.3 |
| School Psychologist | 14 | 17.9 | 24.1 |
| School Social Worker | 4 | 5.1 | 6.9 |
| | | | |
| Saw only MH profs *outside* of school | 26 | 33.3 | 44.8 |
| Saw only MH profs *in* school[4] | 3 | 3.8 | 5.2 |
| Consulted with *both* in-school and outside MH profs | 29 | 37.2 | 50.0 |
| | | | |
| Type of MH treatments accessed prior to college | | | |
| Psychiatric medications | 44 | 56.4 | 75.9 |
| Cognitive Behavioral Therapy | 35 | 44.9 | 60.3 |
| Other types of "talk" therapy | 30 | 38.5 | 51.7 |
| In-patient Hospitalization | 15 | 19.2 | 25.9 |
| Partial Hospitalization | 12 | 15.4 | 20.7 |
| Dialectical Behavior Therapy | 12 | 15.4 | 20.7 |
| Residential treatment | 5 | 6.4 | 8.6 |
| Other | 5 | 6.4 | 8.6 |

*Note.* "MH profs," above, is an abbreviation for "mental health professionals"
[1]A total of 55 respondents consulted with MH provider outside of school at some point before completing HS.
[2]Nutritionists were consulted by some of the respondents in treatment for eating disorders
[3]A total of 32 respondents consulted with a school-based MH provider at some point before completing HS.
[4]Of the 3 survey respondents who saw only school-based MH care professionals, all three of these staff were school counselors

**Hospitalizations and missed school.** Table 6.5.3 displays results for number and length of psychiatric hospitalizations during secondary school, as well as related school absences. Eighteen of the respondents (23.1%) were hospitalized at least once during middle school or high school. Among these 18 students, 7 (9.0%) had just one hospital admission, 6 (7.7%) had two admissions, 2 (2.6%) had three admissions, and 3 (3.8%) respondents had four or more hospital admissions. These hospitalizations ranged in length from three days to twelve weeks, with six lasting less than 1 week, four lasting 2 weeks, another 4 lasting one month, and the remaining 14 hospital stays ranging in length from nine to twelve weeks (approximately two to three months).

Of the eighteen survey respondents who were hospitalized at least once in high school, 14 (77.8% of this sub-group) missed school because of this. Their time out of school ranged from less than one week to more than nine weeks.

**Non-medical services and other mental health supports accessed prior to college.** The bottom section of Table 6.5.3 shows that 57 of the respondents (73.1%) did not access any non-medical mental health services or supports prior to college. Ten students did access social media sites related to youth mental health, and eight accessed the "National Alliance on Mental Illness" (NAMI) either through the organization's website or through their on-campus and in-school clubs, "NAMI on Campus." In addition, five respondents were involved with the youth mental health non-profits "Active Minds" or "Let's Erase the Stigma," one reported attending a community clubhouse for people with serious mental illness, and five selected "Other," signifying their use of additional types of non-medical mental health supports.

Table 6.5.3

*Secondary School Mental Health – Hospitalizations, Missed School, and Non-medical Supports*

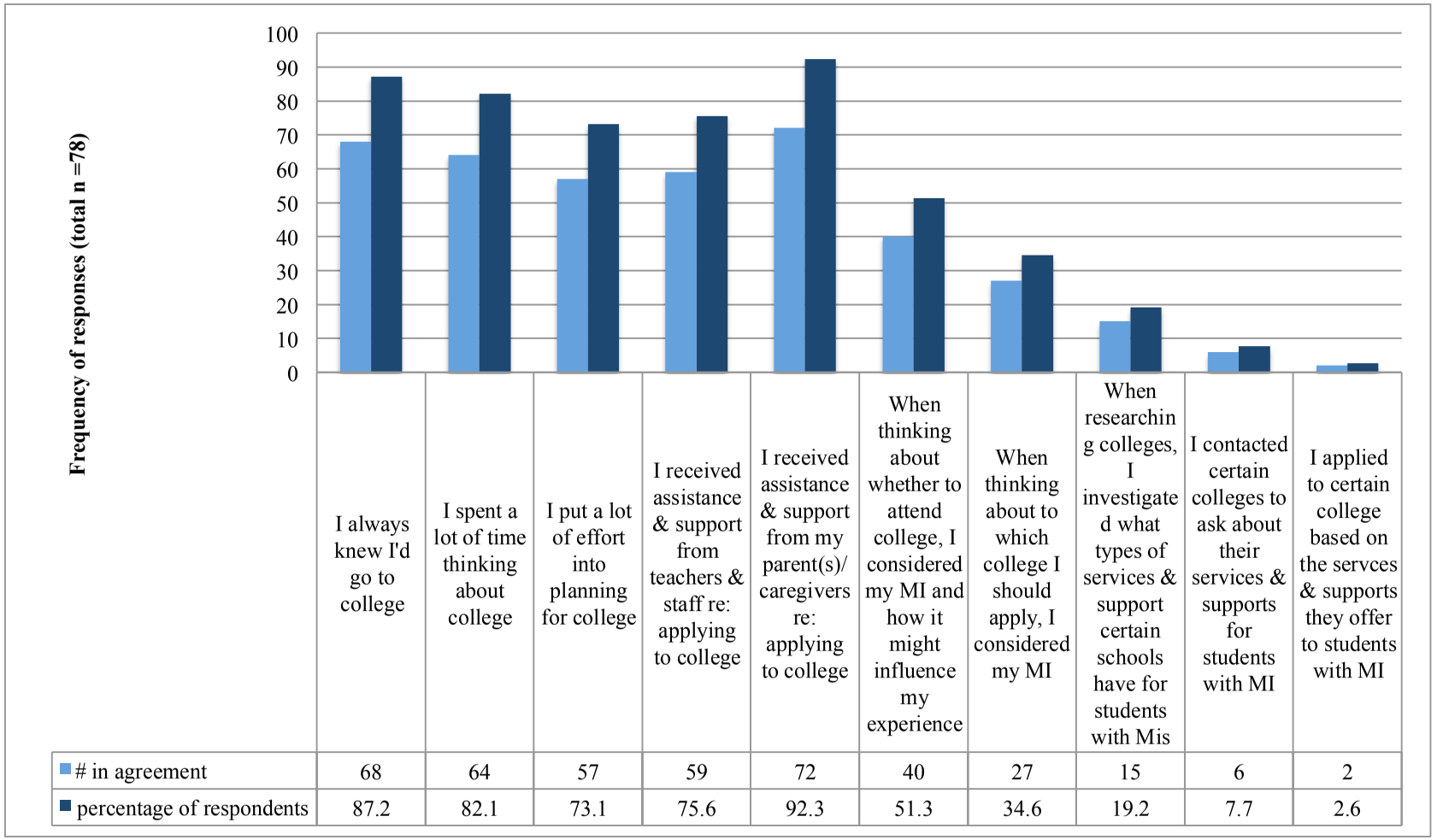
| | n | % (n = 78) | % hospitalized during HS (n=18) |
|---|---|---|---|
| **School missed due to MH** | | | |
| Had at least one hospitalization in middle or HS | 18 | 23.1 | 100.0 |
| Number of hospitalizations in middle or HS | | | |
| 1 admission | 7 | 9.0 | 38.9 |
| 2 admissions | 6 | 7.7 | 33.3 |
| 3 admissions | 2 | 2.6 | 11.1 |
| 4+ admissions | 3 | 3.8 | 16.7 |
| Time spent in hospital during middle or high school | | | |
| ≤ 1 week | 6 | 7.7 | 33.3 |
| 2 weeks | 4 | 5.1 | 22.2 |
| 4 weeks | 4 | 5.1 | 22.2 |
| 5-8 weeks | - | | |
| 9-12 weeks | 14 | 5.1 | 22.2 |
| Hospital stays caused HS absences | 14 | 17.9 | 77.8 |
| Time spent out of school due to hospitalization in middle or HS | | | |
| ≤ 1 week | 2 | 2.6 | 11.1 |
| 2 weeks | 2 | 2.6 | 11.1 |
| 4 weeks | 6 | 7.7 | 33.3 |
| 7-8 weeks | 2 | 2.6 | 11.1 |
| 9+ weeks | 1 | 1.3 | 5.6 |

| | n | % (n = 78) |
|---|---|---|
| **Non-medical services, orgs, or other MH supports accessed prior to college** | | |
| None | 57 | 73.1 |
| Social media sites related to youth MH | 10 | 12.8 |
| National Alliance on Mental Illness (NAMI) | 8 | 10.3 |
| Other | 5 | 6.4 |
| Active Minds | 2 | 2.6 |
| Let's Erase the Stigma | 3 | 3.8 |
| Community "club house" for people w/ MI | 1 | 1.3 |

**College "Readiness" Overview**

Figures 6.2.1 through 6.2.6 display survey findings related to respondents' experiences thinking about college, planning for it, and applying to college. Figure 6.2.1 displays the results that are then divided and displayed separately in Figures 6.2.2, 6.2.3, and 6.2.4. Key take-aways here are the following: (1) the vast majority of respondents (68, 87.2%) "always [knew] they'd go to college" and "spent a lot of time thinking about college"; and (2) although the majority of respondents received assistance and support from both parents and teachers regarding applying to college, only approximately half of these students (40, 51.3%) considered their mental illness when deciding *whether* to go to college. It seems likely that parents and other involved adults did not broach the topic of mental health and how it might affect college with these students. In addition, only 27 respondents (34.6%) considered their mental illness when thinking about to *which* colleges they should apply. This is surprising in light of the fact that many students had significant mental health challenges in high school. Along these lines, only 15 respondents (19.2%) investigated the types of mental health services and supports various colleges offer to students with psychiatric disabilities. Even fewer students (6, 7.7%) actually contacted colleges and universities directly to inquire about such services and supports, and only 2 students (2.6%) applied to a particular college based on the mental health services and supports it offers.

College Readiness: Expectations, Assistance Received, and Consideration of Mental Illness




| | I always knew I'd go to college | I spent a lot of time thinking about college | I put a lot of effort into planning for college | I received assistance & support from teachers & staff re: applying to college | I received assistance & support from my parent(s)/ caregivers re: applying to college | When thinking about whether to attend college, I considered my MI and how it might influence my experience | When thinking about to which college I should apply, I considered my MI | When researching colleges, I investigated what types of services & support certain schools have for students with Mis | I contacted certain colleges to ask about their services & supports for students with MI | I applied to certain college based on the servces & supports they offer to students with MI |
|---|---|---|---|---|---|---|---|---|---|---|
| # in agreement | 68 | 64 | 57 | 59 | 72 | 40 | 27 | 15 | 6 | 2 |
| percentage of respondents | 87.2 | 82.1 | 73.1 | 75.6 | 92.3 | 51.3 | 34.6 | 19.2 | 7.7 | 2.6 |

*Figure 6.2.1*. Possible statements in response to survey prompt "When I was in High School…" Respondents selected an answer from a 5-point Likert scale ranging from "Strongly Agree" [5] to "Strongly Disagree" [1] each of the above statements. Selections of "Strongly Agree" or "Agree" were totaled for each statement and are included in the bar graph. Selections of "Not sure" [3], "Disagree" [2], or "Strongly Disagree" [1] are not included. Note that "MI," above, is an abbreviation for "mental illness."

Expectations for College

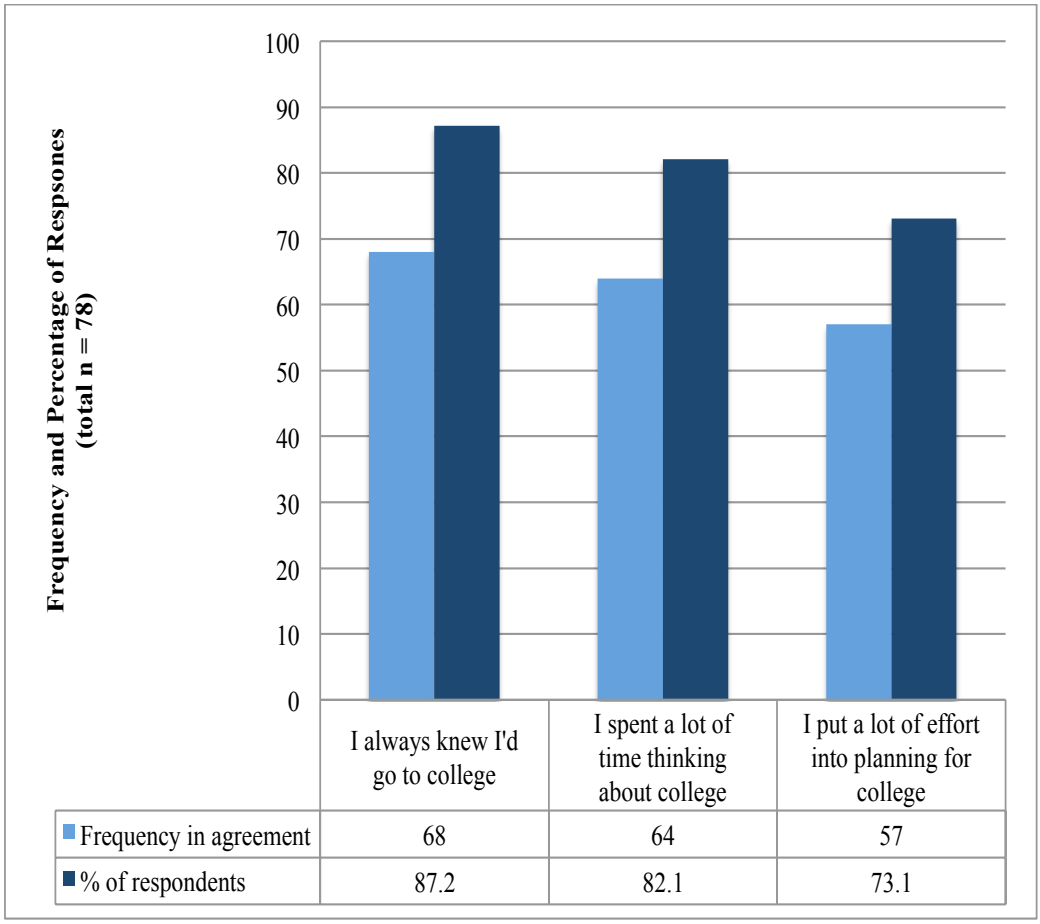



*Figure 6.2.2* Possible statements in response to survey prompt "When I was in High School…" Respondents selected an answer from a 5-point Likert scale ranging from "Strongly Agree" [5] to "Strongly Disagree" [1] for each of the above statements. Selections of "Strongly Agree" or "Agree" were totaled for each statement and are included in the bar graph, above. Selections of "Not sure" [3], "Disagree" [2], or "Strongly Disagree" [1] are not included in this graph.

A total of 68 survey respondents (87.2% of the sample) reported that they "always knew" they would go to college, while 64 respondents (82.1%) claimed spending "a lot of time thinking about college" when they were in high school. And, finally, 57 respondents (73.1%) reported putting "a lot of effort into planning for college." These findings show that the majority of respondents planned to attend college and spent what they feel was significant time thinking about and planning for this life transition while they were in secondary school.

Assistance Received when Applying to College

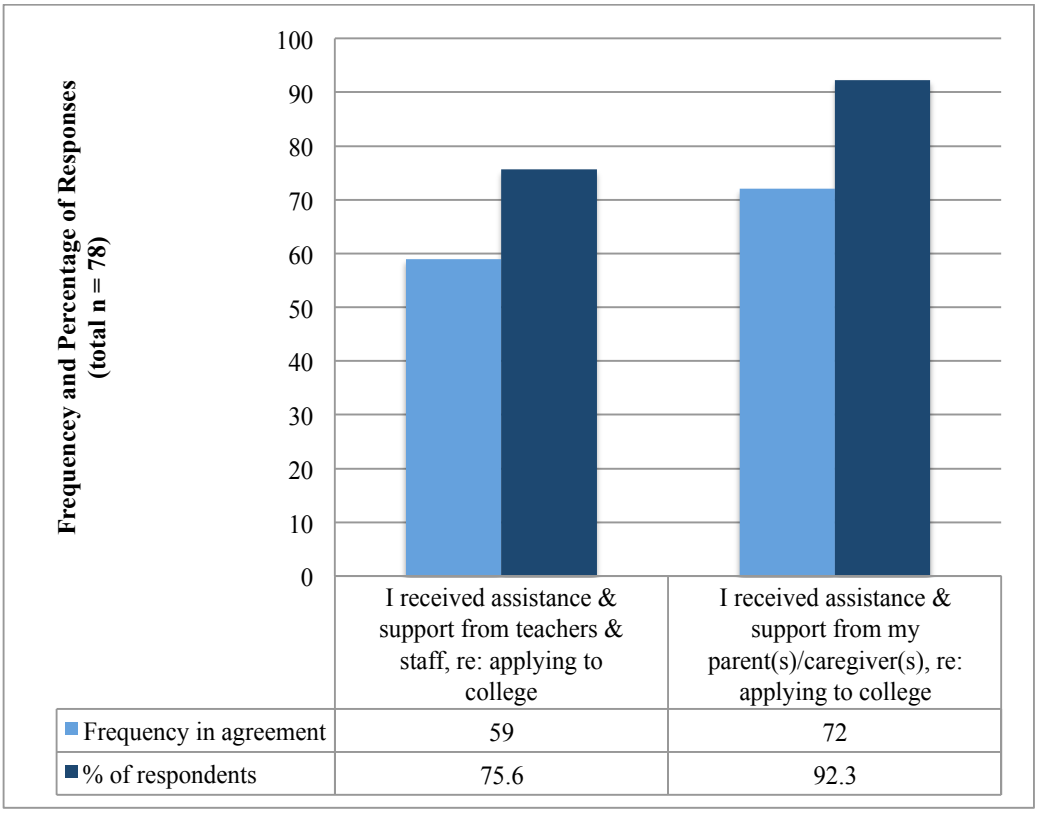



*Figure 6.2.3* Possible statements in response to survey prompt "When I was in High School…" Respondents selected an answer from a 5-point Likert scale ranging from "Strongly Agree" [5] to "Strongly Disagree" [1] for each of the above statements. Selections of "Strongly Agree" or "Agree" were totaled for each statement and are included in the bar graph, above. Selections of "Not sure" [3], "Disagree" [2], or "Strongly Disagree" [1] are not included in this graph.

A total of 59 survey respondents (75.6% of the sample) reported having received assistance and support from their teachers and/or school staff when applying to college; 72 respondents (92.3%) reported having received assistance from their parents or caregivers. These findings show that the majority of survey respondents received some sort of assistance from high school staff and/or their parents in the application process.

Consideration of Mental Illness when Applying to College

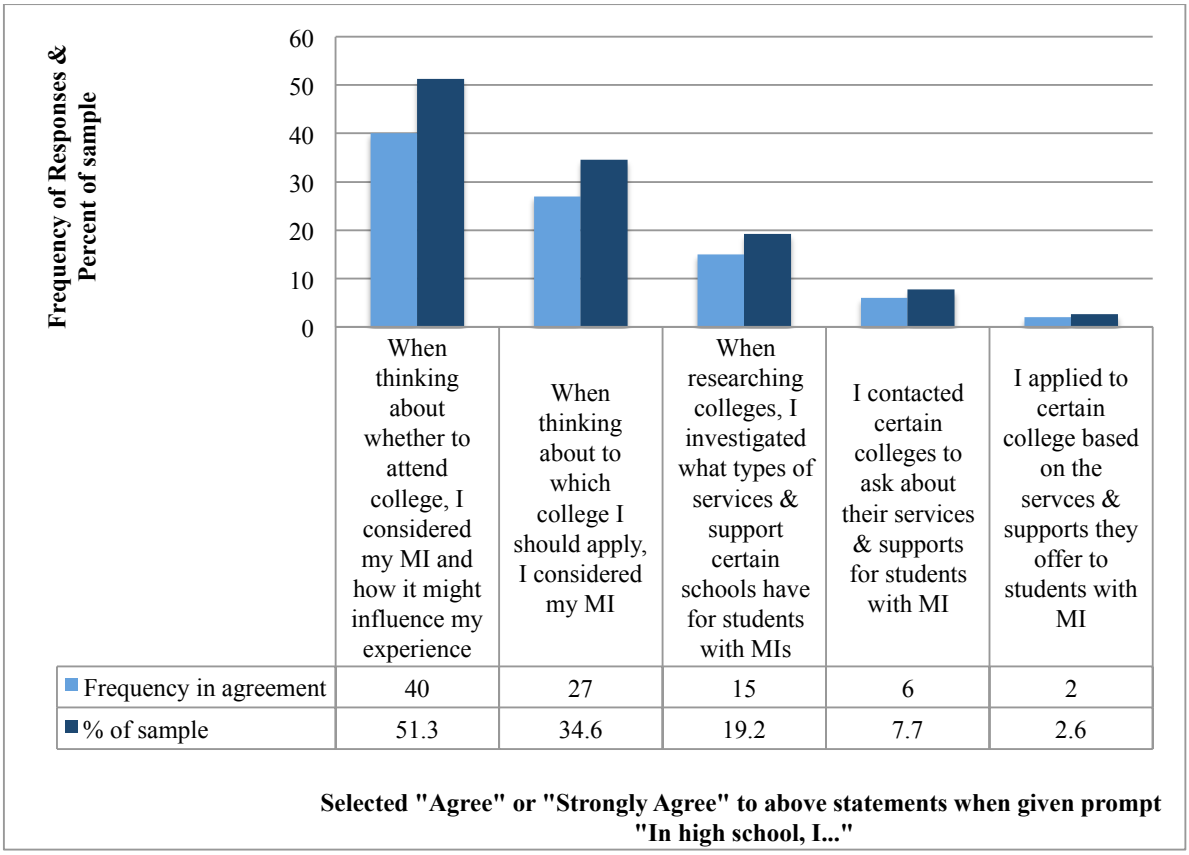



*Figure 6.2.4* The above graph shows the frequency of statements in response to the survey prompt "When I was in High School…"

Respondents selected an answer from a 5-point Likert scale ranging from "Strongly Agree" [5] to "Strongly Disagree" [1] for each of the above statements. Selections of "Strongly Agree" or "Agree" were totaled for each statement and are included in the bar graph, above. Selections of "Not sure" [3], "Disagree" [2], or "Strongly Disagree" [1] are not included in this graph.

A total of 40 survey respondents (51.3% of the sample) reported considering their mental illness (MI) when thinking about *whether* to attend college; 27 respondents (34.6%) reported considering their mental illness when thinking about the colleges to which they might apply; and 15 respondents (19.2%) reported investigating the type of mental-health related services and

supports certain colleges and universities offer. Only 6 respondents (7.7% of the sample) contacted certain colleges to actually inquire about the services and supports these institutions provide for students with mental illnesses, and 2 respondents (2.6%) applied to a particular institution of higher education based on that school's available services and supports for students with mental illness.

These findings show that approximately half of the survey respondents considered their mental health status when deciding *whether* to apply to college, while the remaining half did not. In addition, the majority of respondents (approximately 65%) did not consider their mental illness or mental health history, symptoms, or treatment needs when deciding to *which* colleges they should apply. Continuing this trend, a majority of respondents (approximately 80%) did not research how various schools differ in terms of what services and supports they offer to students with psychiatric disabilities (e.g. counseling center programs, medical leave policies, types of academic accommodations offered, etc.). And, finally, a large majority of respondents (92%) did not contact various colleges to inquire about these schools' mental-health related services and supports for students, and they did not apply to certain schools based on those schools' available services (97%).

We can interpret these findings to mean that while up to half of students with serious mental health conditions may reflect on *whether* to go to college, the vast majority are not likely to consider their mental health in relation to college attendance much beyond this issue.

Most students do not explore how their particular mental health needs may or may not be met on various college campuses.

**Knowledge of disability legislation and accommodations**. Figure 6.2.5, below, shows that only 18 students (23.1%) considered whether to access academic accommodations in college prior to actually enrolling, and only 16 (20.5%) learned about accommodations before college. In addition, only 16 of the respondents (20.5%) had a parent discuss accessing academic accommodations in college with them prior to going, and only 12 (15.4%) had a high school teacher or staff person broach the subject. Clearly, the majority of respondents did not know about accommodations when they were applying to college, and/or they did not think about how or why accommodations might be utilized. Respondents were largely unaware of disability-related legislation such as the ADA, Section 504 of the Rehabilitation Act, and IDEA, and what these laws mean for youth and/or adults with disabilities in schools and universities. Only 18 respondents (23.1%) knew of services and supports available to students with disabilities at the colleges to which they applied, and only 14 respondents (17.9%) knew how students with mental illness could access academic accommodations at the colleges to which they applied.

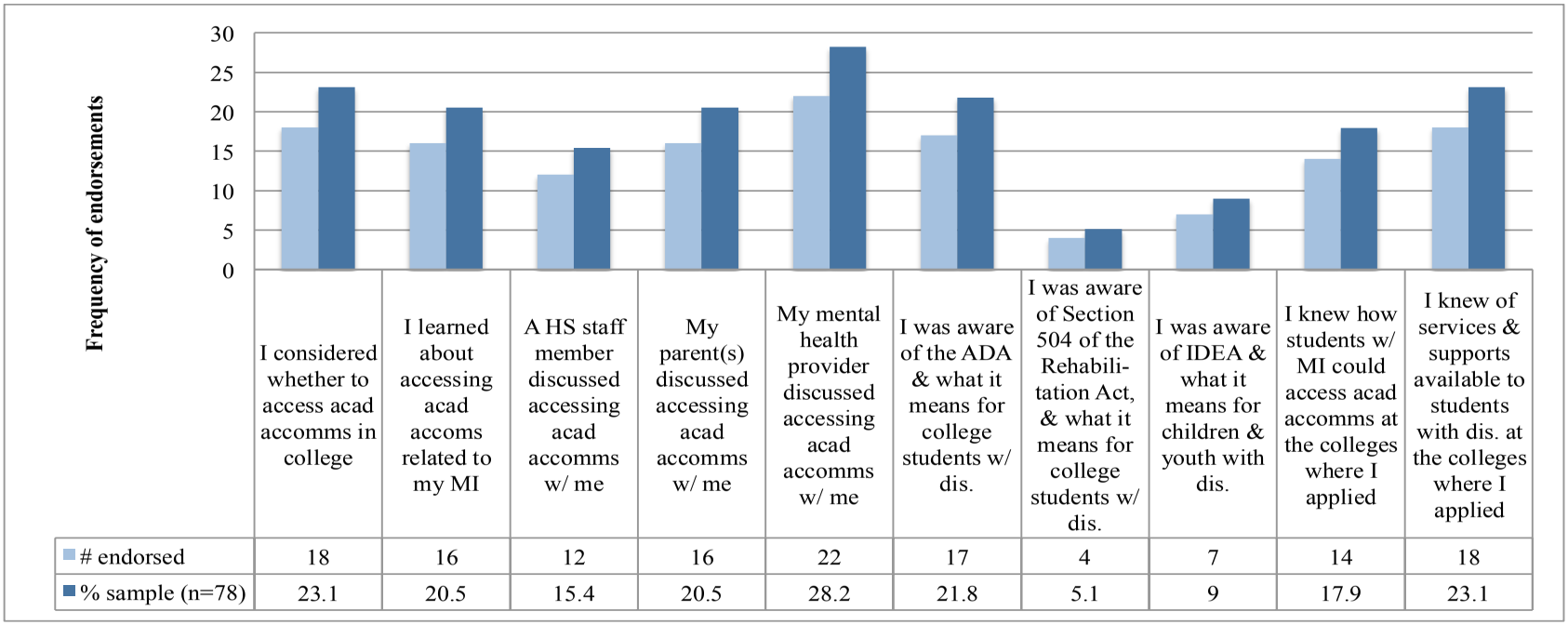
Taken together, these findings show that despite spending a lot of time "thinking about college" and putting "a lot of effort" into planning for this major life transition, most of the young people in this sample did not think about college in relation to their mental health histories or diagnoses.

**Reasons for considering colleges' geographic locations.** Sixty-six respondents reported that they considered colleges geographic locations when selecting and applying

to schools. Figure 6.2.6 displays the reasons that these respondents gave for this consideration, in descending order from left to right. Thirty-three respondents (50% of this sub-group) reported that they "wanted to be independent from" their parents or caregivers and "live on [their] own." This finding makes sense in the context of emerging adult development and young people's increasing desire for independence. However, another group of students – and nearly as large (29, 43.9%) reported that they considered colleges' locations because they "wanted to be close enough to parents to drive home if [they] needed a break from school." This second finding speaks to the fact that many respondents also want to maintain a physical connection to home, and that they are negotiating the autonomy of college with the need for continued "relatedness" to family.

It is also noteworthy that the third most common reason for considering a college's location is "to start over in a new place where no one knows about [his or her] mental illness." Sixteen respondents (24.2% of the 66 who considered location) endorsed this reason, foregrounding the importance that many students put on having a "clean slate" in college and of not necessarily having to tell anyone about their pasts, including their mental health diagnoses. This result also highlights the optimism that many college students have in terms of putting things "behind" them and starting fresh in a brand new environment full of opportunity.

Knowledge of Disability Legislation and Accommodations Prior to College

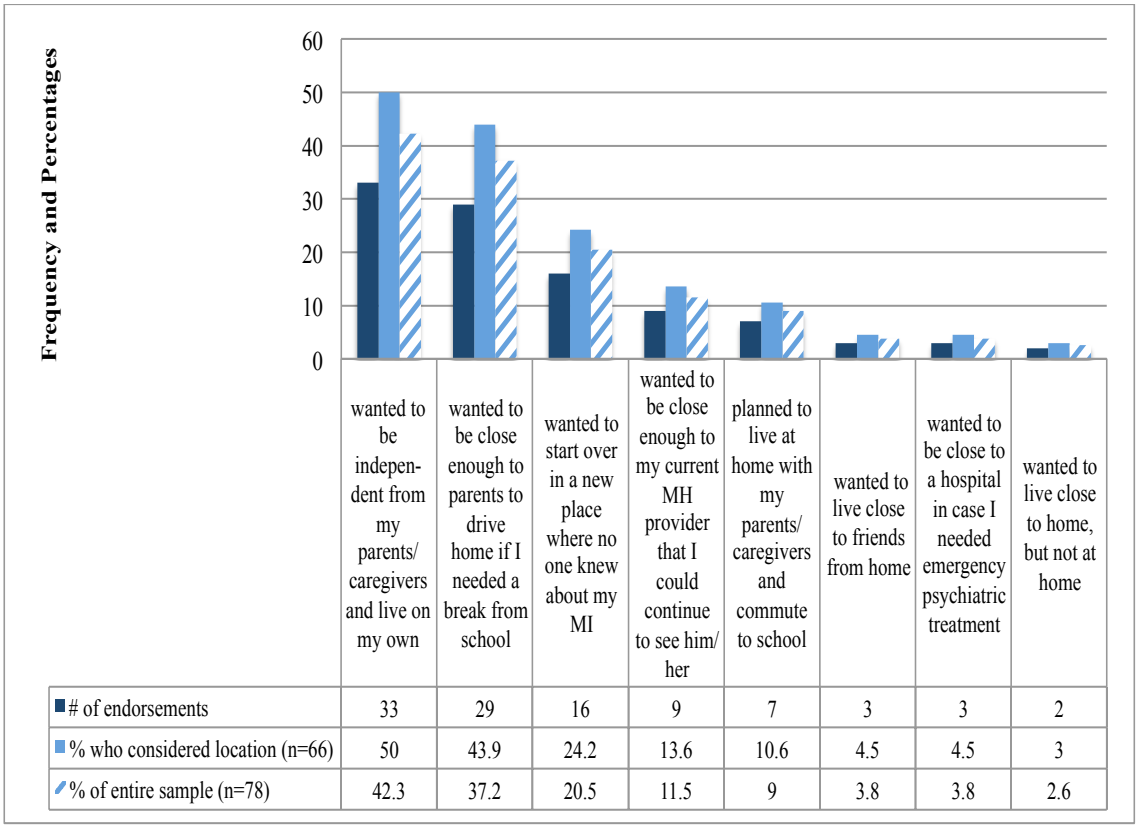



| | I considered whether to access acad accomms in college | I learned about accessing acad accoms related to my MI | A HS staff member discussed accessing acad accomms w/ me | My parent(s) discussed accessing acad accomms w/ me | My mental health provider discussed accessing acad accomms w/ me | I was aware of the ADA & what it means for college students w/ dis. | I was aware of Section 504 of the Rehabili-tation Act, & what it means for college students w/ dis. | I was aware of IDEA & what it means for children & youth with dis. | I knew how students w/ MI could access acad accomms at the colleges where I applied | I knew of services & supports available to students with dis. at the colleges where I applied |
|---|---|---|---|---|---|---|---|---|---|---|
| # endorsed | 18 | 16 | 12 | 16 | 22 | 17 | 4 | 7 | 14 | 18 |
| % sample (n=78) | 23.1 | 20.5 | 15.4 | 20.5 | 28.2 | 21.8 | 5.1 | 9 | 17.9 | 23.1 |

*Figure 6.2.5.* This bar chart displays frequencies for responses to the prompt "When preparing for or applying to college…" Survey respondents were asked to rate statements on a 5-point Likert scale from "Strongly Agree" [5] to "Strongly Disagree" [1]. This chart displays the combined "Strongly Agree" and "Agree" responses for each item.

The majority of respondents did not learn about or consider accessing accommodations in college prior to actually matriculating. In addition, very few respondents report being aware of any of the federal legislation that protects people with disabilities and ensures their access to education.

Reasons for Considering Colleges' Geographic Locations




| | wanted to be indepen-dent from my parents/ caregivers and live on my own | wanted to be close enough to parents to drive home if I needed a break from school | wanted to start over in a new place where no one knew about my MI | wanted to be close enough to my current MH provider that I could continue to see him/ her | planned to live at home with my parents/ caregivers and commute to school | wanted to live close to friends from home | wanted to be close to a hospital in case I needed emergency psychiatric treatment | wanted to live close to home, but not at home |
|---|---|---|---|---|---|---|---|---|
| # of endorsements | 33 | 29 | 16 | 9 | 7 | 3 | 3 | 2 |
| % who considered location (n=66) | 50 | 43.9 | 24.2 | 13.6 | 10.6 | 4.5 | 4.5 | 3 |
| % of entire sample (n=78) | 42.3 | 37.2 | 20.5 | 11.5 | 9 | 3.8 | 3.8 | 2.6 |

*Fig. 6.2.6.* This bar chart displays the reasons that survey respondents (n=66) gave for considering a college's geographic location during their college selection and application process. Survey respondents who answered "Strongly Agree" or "Agree" to the prompt, "I considered colleges' geographic locations when thinking about which school to attend"(survey question Q6-21) were then asked to "please check the boxes next to statements that are most accurate for you" (survey question Q6-22) when given the above reasons.

**Use and Assessment of SDS & Academic Accommodations in College**

Table 6.6 shows paired sample *t*-test results comparing having an Individualized Education Program (IEP) in high school and accessing academic accommodations through on-campus Student Disability Services in college. There is a significant difference between mean scores on these measures, with more students using accommodations in college than had IEPs in high school. The bar chart in Figure 6.3.1 shows that while only 12 respondents (15.4%) had IEPs in high school (meaning that they were identified by their schools as having a disability), 31 (39.7%) respondents accessed academic accommodations at some point during college.

Table 6.6

Individualized Education Program (IEP) in High School and Use of Academic Accommodations in College: Paired Samples

Paired Samples Statistics

| | | Mean | N | Std. Deviation | Std. Error Mean |
|---|---|---|---|---|---|
| Pair 1 | Did you have an IEP ("Individual Education Plan") in HS? | 1.81 | 64 | .393 | .049 |
| | Because of my MI, I have accessed services (e.g. academic accommodations) on my campus. | 1.56 | 64 | .500 | .063 |

Paired Samples Correlations

| | | N | Correlation | Sig. |
|---|---|---|---|---|
| Pair 1 | Did you have an IEP…in HS? & Because of my MI, I have accessed services (e.g. academic accommodations) on my college campus. | 64 | .141 | .266 |

Paired Samples Test

| | | Paired Differences | | | | | t | df | Sig. (2-tailed) |
|---|---|---|---|---|---|---|---|---|---|
| | | Mean | Std. Deviation | Std. Error Mean | 95% Confidence Interval of the Difference Lower | Upper | | | |
| Pair 1 | Did you have an IEP in HS? - Because of my MI, I have accessed SDS (e.g. academic accommodations) on my college campus. | .250 | .591 | .074 | .102 | .398 | 3.384 | 63 | .001* |

The mean scores for having an IEP in High School and accessing academic accommodations via Student Disability Services in College are weakly and positively correlated (r = .141, *p*=.266), but the correlation is not significant. There *is* a significant difference between mean scores for having an IEP in High School and accessing academic accommodations via Student Disability Services in College

($t_{63}$ = 3.38, $p$ = .001)

The mean score for students accessing academic accommodations in College is .25 points lower (where 1 = "Yes" and 2 = "No") than the mean score for students having an IEP in High School

(95% CI [.10, .40]). Note that a *lower* score here denotes higher likelihood of accessing accommodations in college.

*$p \leq .001$

Indeed, while 12 of the survey respondents had IEPs in high school (15.4%) and received related Special Education services, a total of 66 (84.6%) did not. In contrast 31 of the respondents accessed academic accommodations through their campus Student Disability Services (SDS) at some point during college. This is approximately 40% of the total sample and represents a significant increase in use of disability and academic supports between secondary school and higher education. Despite this increase, however, the fact remains that over 60% of the survey participants did *not* identify themselves as students with disabilities at campus Disability Services, foregoing accommodations that may have benefited them.

Bar Chart displaying Survey Respondents with IEPs in High School vs. those Using Academic Accommodations through Student Disability Services in College

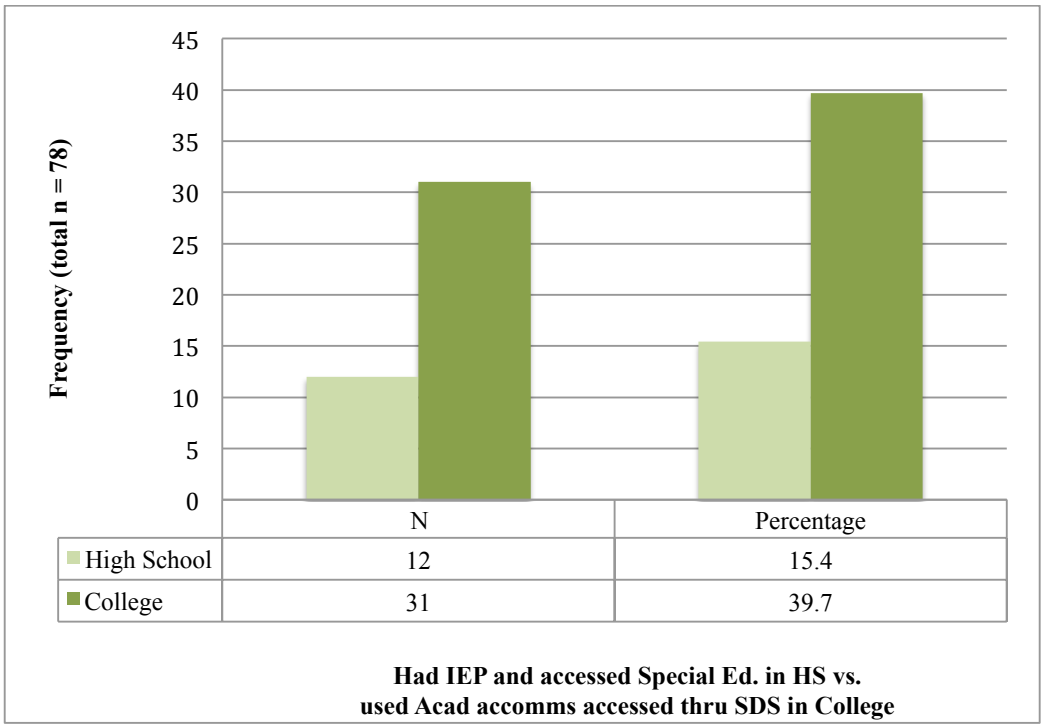



*Figure 6.3.1.* There are significantly more students who utilize academic accommodations in college through their campus' Student Disability Services office than there are students who had Individualized Education Programs (IEPs) in High School. (For details on the statistics for this pair of variables, see Table 6.6)

It is difficult to say why this is the case, but the finding may be partially dependent on time spent in college (an avenue for further investigation). It could be that as college students mature and become more experienced with higher education and its demands over time, they also become more likely to advocate for themselves to support their academic success. Such advocacy could manifest in a request for services through SDS.

Another possibility is that – as some of the participants in this study experienced – students may enter college and not access accommodations believing that they will not need them. However, they may then experience academic difficulties related to their mental health, or even a hospitalization or medical leave, and this may motivate them to seek support through accommodations. This latter possibility is more a *reaction* to a negative event or events, while the former possibility is a *prevention* approach to accommodations.

Figure 6.3.2 displays evaluations of academic accommodations in college by the students who accessed them. A total of 31 students used accommodations and the majority of them had positive experiences doing so.

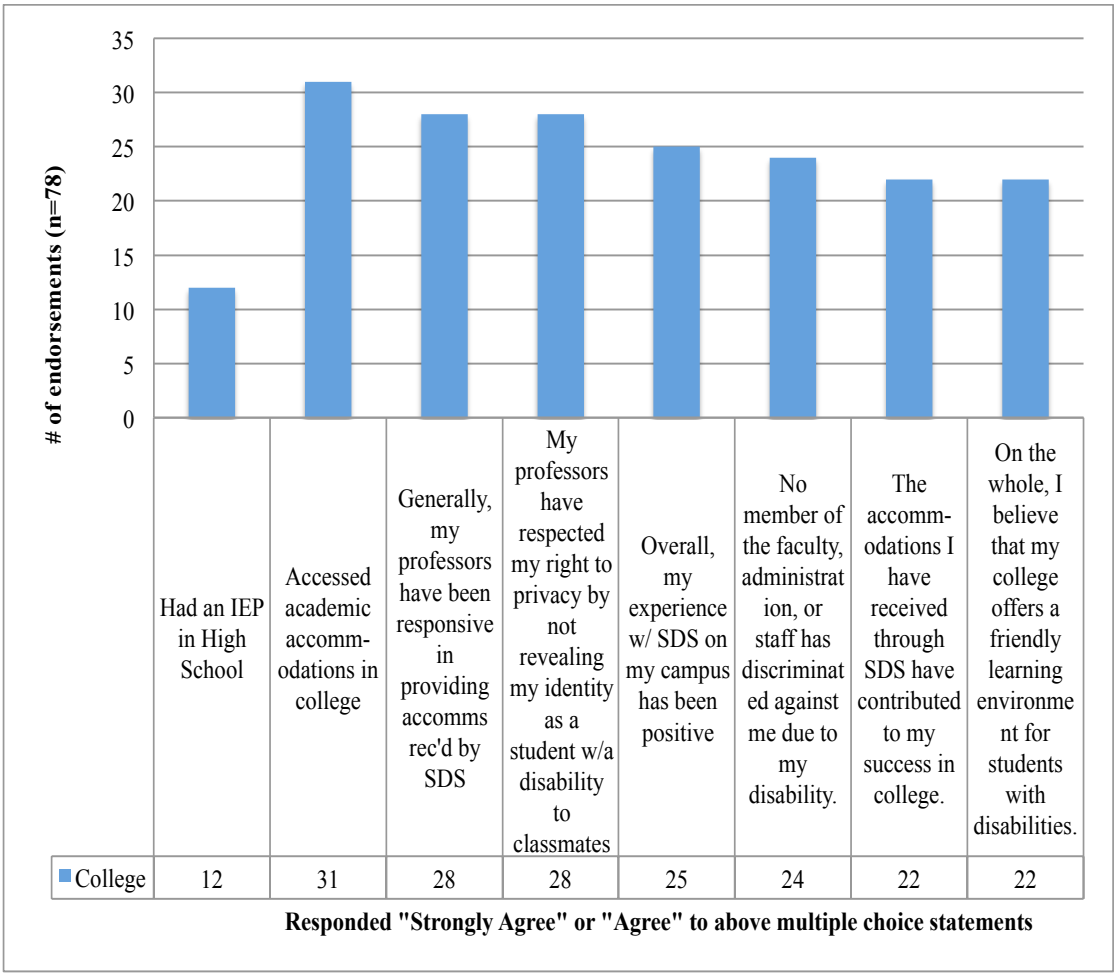



*Figure 6.3.2.* The two left-most bars in the chart above show that 12 survey respondents had an IEP in high school (15.4% of the total sample of 78) and 31 respondents utilized academic accommodations in college (39.7% of the total sample). The remaining six bars display the number of endorsements for each multiple-choice statement regarding Student Disability Services. Note that responses for these six items are from the 31 students who did, in fact, use SDS at some point in college.

Twenty-eight respondents (90.3% of those who accessed SDS) feel that their professors were "responsive in providing accommodations recommended by SDS"; another 28 students (90.3%) feel that their professors "respected [their] right to privacy by not revealing" their disability status to classmates; 25 respondents (80.6% of the SDS users) feel that their experience with SDS, overall, was "positive"; 24 (77.4%) feel that they have not been discriminated against by any faculty or staff due to identifying as a student with a disability; 22 respondents (71%) believe that the academic accommodations they received have contributed to their success in college; and a final 22 (71%) SDS users feel that their college "offers a friendly learning environment for students with disabilities."

Taken together, these results show that the majority of students who did access accommodations in college had positive experiences doing so. But as is mentioned in Figure 6.3.1, we do not know how long each of the SDS users was in college prior to first accessing accommodations.

**Reasons for accessing academic accommodations**. Respondents endorsed multiple reasons for choosing to access academic accommodations in college. Figure 6.3.3, below, displays these reasons.

Reasons for Accessing Academic Accommodations in College

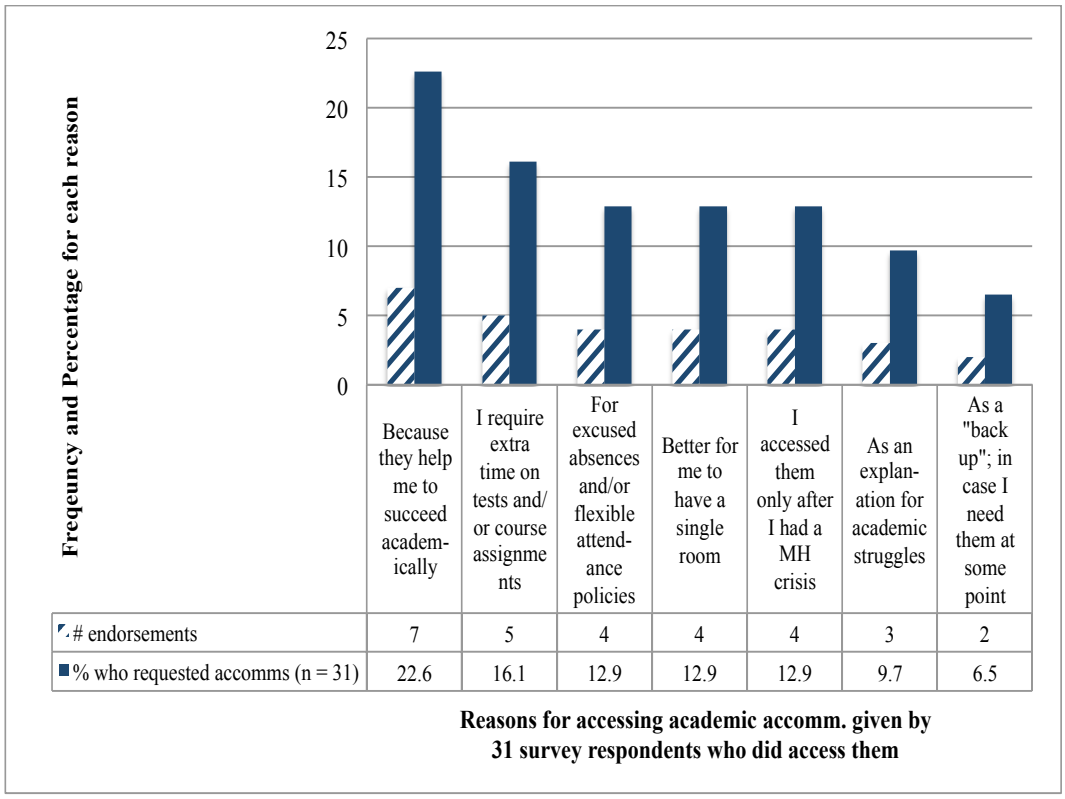
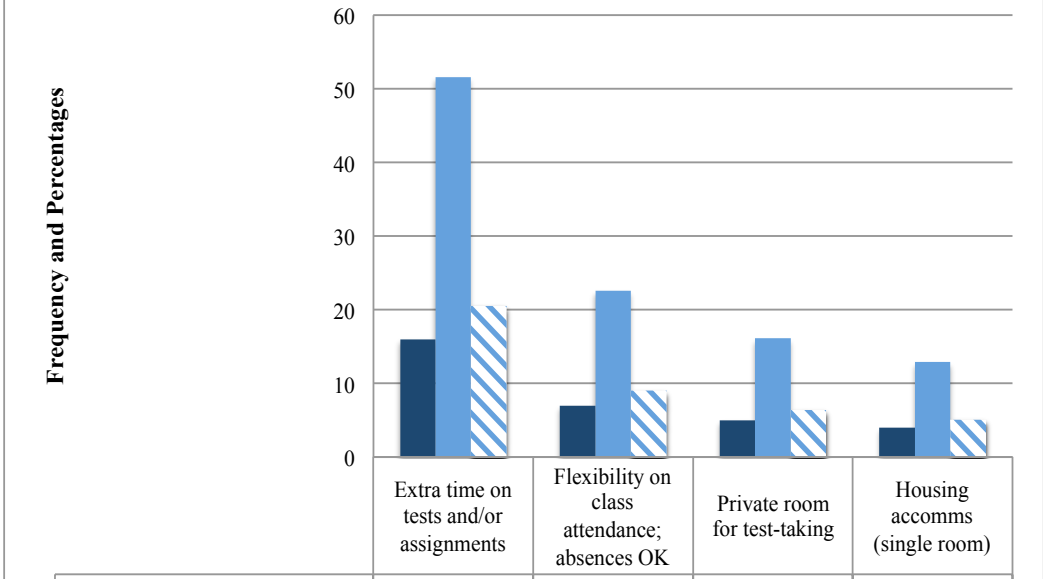



*Figure 6.3.3.* This bar chart displays reasons endorsed by the 31 survey respondents who accessed academic accommodations through their campus Student Disability Services. The bars are arranged in descending order from left to right, with "they help me to succeed academically" as the most popular reason for accessing services. Note that 4 respondents (12.9% of the 31 who utilized SDS) reported that they accessed them "only after [having] a mental health crisis, while an additional 3 respondents (9.7%) accessed services "as an explanation for academic struggles." Both of these reasons highlight the troubling finding that many students who might qualify for academic accommodations do not utilize them until *after* challenges arise, as opposed to using them to prevent struggle and to support success.

**Types of academic accommodations used.** Respondents also reported using various types of accommodations. Figure 6.3.4, below, displays the top four types of accommodations accessed in college.

Types of Academic Accommodations Used in College

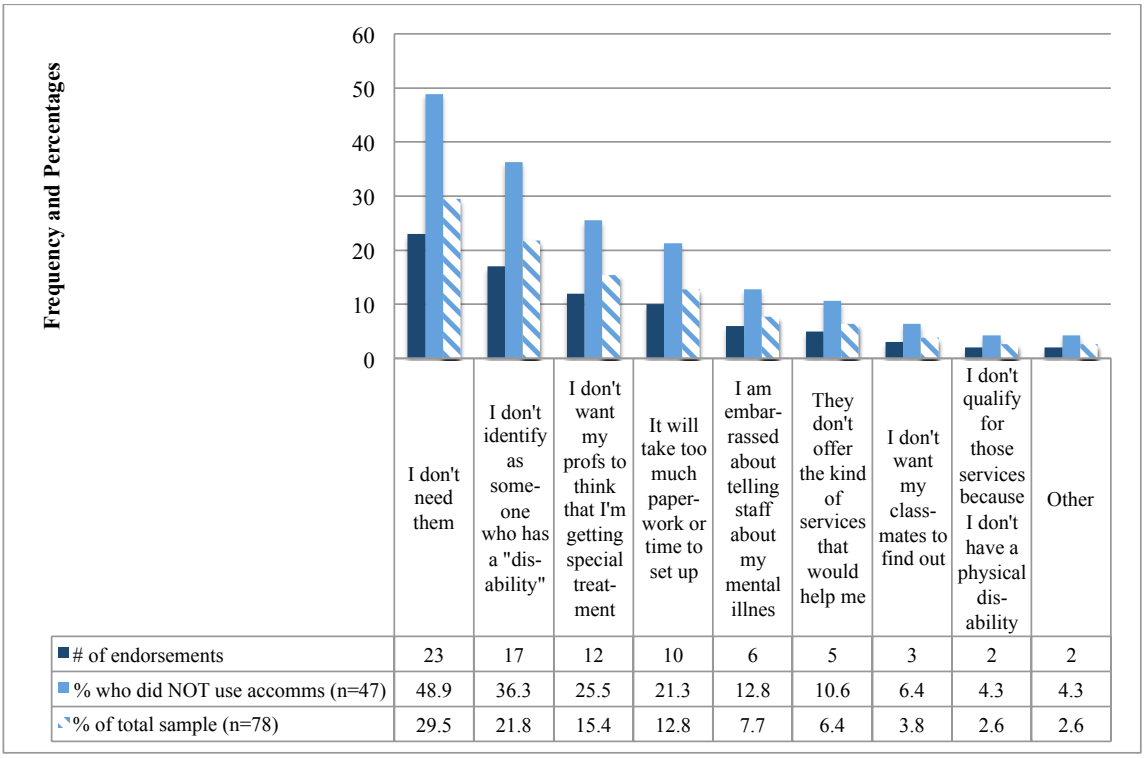



| | Extra time on tests and/or assignments | Flexibility on class attendance; absences OK | Private room for test-taking | Housing accomms (single room) |
|---|---|---|---|---|
| # of endorsements | 16 | 7 | 5 | 4 |
| % of people requesting accomms | 51.6 | 22.6 | 16.1 | 12.9 |
| % of total sample | 20.5 | 9 | 6.4 | 5.1 |

*Fig. 6.3.4.* This bar chart depicts the types of academic accommodations used by certain survey respondents in college. Open-ended responses to the prompt "Please describe why you chose to access accommodations in the space below" were given by the 31 respondents who did, in fact, request accommodations. These open-ended responses were then sorted and organized into the four "type" categories, above. The frequency of use for each type of accommodation, as well as the percent of students who accessed accommodations using each type (n=31), and the percentage of the entire sample (n=78) are represented in this bar chart.

**Reasons for *not* using academic accommodations.** Respondents also have multiple reasons, displayed below, for opting against accommodations.

Reasons for *not* Utilizing Academic Accommodations in College




| | I don't need them | I don't identify as some-one who has a "dis-ability" | I don't want my profs to think that I'm getting special treat-ment | It will take too much paper-work or time to set up | I am embar-rassed about telling staff about my mental illnes | They don't offer the kind of services that would help me | I don't want my class-mates to find out | I don't qualify for those services because I don't have a physical dis-ability | Other |
|---|---|---|---|---|---|---|---|---|---|
| # of endorsements | 23 | 17 | 12 | 10 | 6 | 5 | 3 | 2 | 2 |
| % who did NOT use accomms (n=47) | 48.9 | 36.3 | 25.5 | 21.3 | 12.8 | 10.6 | 6.4 | 4.3 | 4.3 |
| % of total sample (n=78) | 29.5 | 21.8 | 15.4 | 12.8 | 7.7 | 6.4 | 3.8 | 2.6 | 2.6 |

*Fig. 6.3.5.* This bar chart depicts reasons given by the survey respondents who did not use academic accommodations on their campus' Student Disability Services offices (n=31). It shows the percentage of this sub-group that endorsed each reason for fore-going accommodations, as well as what these percentages are for the entire survey sample (n=78). Respondents who selected "No" to the prompt, "Because of my mental illness, I have accessed services (e.g. academic accommodations) on my campus through the Student Disability Services office" (survey question Q7-44) were automatically bumped to a question asking them to select from the above statements regarding their reasons for this decision (survey question Q7-53). Respondents were asked to "please select all that apply."

In addition, "profs," above, is an abbreviation for "professors."

**College Mental Health**

As seen in Table 6.7.1, 73 respondents (93.6%) have seen at least one mental health professional since beginning college. Fifty of these 73 students (68.5%) accessed services at their campus' Counseling and Psychological Services (CAPS) center; 22 (30.1%) saw only off-campus mental health providers; 20 (27.4%) saw only on-campus providers, and 30 (41.2% of the 73 who accessed mental health services in college saw *both* on-campus and off-campus mental health professionals.

The two most common forms of treatment in college are the same as the two most common forms of treatment in high school: (1) medication, and (2) CBT. Sixty respondents (76.9% of the entire sample) have taken prescription psychiatric medications since entering college (recall that 44, or 56.4% took medication high school), and 38 respondents engage in CBT in college (35, or 44.9% did so in high school. Although the preferred treatment modalities remain the same, the trend over time is that more respondents utilized these treatments once in college.

Also noteworthy in this table is the finding that 17 respondents were hospitalized (12 in-patients and 5 in partial hospitalization) during college. (Recall that 18 had also been hospitalized at some point during secondary school). This means that nearly 22% of the sample has experienced at least one hospitalization during college – over one fifth of the sample. Table 6.7.2 shows the number of admissions for the 17 respondents who were hospitalized in college, as well as the length of the stays (ranging from less than one week to eight weeks). The table also shows that 14 of these 17 students missed class in college because of their hospitalizations, and these absences ranged from less than one week up to three years.

Table 6.7.1
*College Mental Health – Services Accessed Since Beginning College*

| | n | % who accessed *on*-campus MH services since starting college (n = 50) | % who accessed *any* MH services since starting college (n=73) | % total sample (n = 78) |
|---|---|---|---|---|
| **Mental Health services since beginning college** | | | | |
| Have seen a MH professional since beginning college | 73 | | 100.0 | 93.6 |
| Have not seen any MH professionals since beginning college | 5 | | 0.0 | 6.4 |
| | | | | |
| Type of MH professionals seen since beginning college | | | | |
| *MH professionals off-campus (outside of college)* | | | | |
| Psychiatrist | 39 | | 53.4 | 50.0 |
| Psychologist | 39 | | 53.4 | 50.0 |
| Counselor | 12 | | 16.4 | 15.4 |
| Clinical Social Worker | 11 | | 15.1 | 14.1 |
| Psychiatric Nurse Practitioner | 3 | | 4.1 | 3.8 |
| Addictions Counselor | 1 | | 1.4 | 1.3 |
| Other | 1 | | 1.4 | 1.3 |
| *MH professionals seen on-campus* | | | | |
| Have accessed services or supports at campus CAPS | 50 | 100.0 | 68.5 | 64.1 |
| Psychiatrist | 27 | 54.0 | 37.0 | 34.6 |
| Psychologist | 27 | 54.0 | 37.0 | 34.6 |
| Counselor | 26 | 52.0 | 35.6 | 33.3 |
| Clinical Social Worker | 4 | 8.0 | 5.5 | 5.1 |
| Psychiatric Nurse Practitioner | 6 | 12.0 | 8.2 | 7.7 |
| Services I accessed at CAPS contribute to my college success | 32 | 64.0 | 43.8 | 41.0 |
| | | | | |
| Have seen only *off*-campus MH professionals | 22 | | 30.1 | 28.2 |
| Have seen only *on*-campus MH professionals | 20 | | 27.4 | 25.6 |
| Have consulted *both* on-campus & off-campus MH professionals | 30 | | 41.2 | 38.5 |
| | | | | |
| Type of MH treatments accessed since beginning college | | | | |
| Psychiatric medications | 60 | | 82.2 | 76.9 |
| Cognitive Behavioral Therapy | 38 | | 52.1 | 48.7 |
| Other "talk" therapy | 38 | | 52.1 | 48.7 |
| In-patient Hospitalization | 12 | | 16.4 | 15.4 |
| Dialectical Behavior Therapy | 8 | | 11.0 | 10.3 |
| Partial Hospitalization | 5 | | 6.8 | 6.4 |
| Residential treatment | 4 | | 5.5 | 5.1 |
| Group Therapy | 1 | | 1.4 | 1.3 |

Table 6.7.2

*College mental health – Hospitalizations & Time Out of School*

| Hospitalizations & residential treatment during college | n | % of respondents in-patient during college (n=17) | % total (n=78) |
|---|---|---|---|
| Had at least one hospitalization or residential treatment admission for MH during college | 17 | 100.0 | 21.8 |
| Number of in-patient treatment stays during college | | | |
| 1 admission | 13 | 76.5 | 16.7 |
| 2 admissions | 2 | 11.8 | 2.6 |
| 3 admissions | 1 | 5.9 | 1.3 |
| 4 admissions | 1 | 5.9 | 1.3 |
| Time spent in hospital during college | | | |
| ≤ 1 week | 9 | 52.9 | 11.5 |
| 1-2 weeks | 4 | 23.5 | 5.1 |
| 4 weeks | 2 | 11.8 | 2.6 |
| 5-8 weeks | 2 | 11.8 | 2.6 |
| **Time spent out of school in college** | | | |
| Hospital stays caused college absences | 14 | 82.4 | 17.9 |
| Total time out of college due to hospitalization or residential treatment in college | | | |
| < 1week | 6 | 35.3 | 7.7 |
| 1-2 weeks | 3 | 17.6 | 3.8 |
| 1 month | 2 | 11.8 | 2.6 |
| 2 months | 2 | 11.8 | 2.6 |
| 4 months | 1 | 5.9 | 1.3 |
| 9 months | 1 | 5.9 | 1.3 |
| 1 year | 1 | 5.9 | 1.3 |
| 3 years | 1 | 5.9 | 1.3 |

**Non-medical supports accessed.** Table 6.7.3 shows respondents' use of non-medical supports in college. When comparing these results with similar results for high school (see Table 6.5.3), we can see that far more students utilize non-medical services, organizations, and other mental heath supports in college than they did in high school. Twenty-one students in total accessed mental health related websites or participated in mental-health related clubs or organizations in high school (26.9%), but 64 students (82.1%) do so once in college. Also noteworthy when comparing Tables 6.5.3 and 6.7.3 are the differences in *Active Minds* participation. This non-profit organization helps to set up mental health awareness and advocacy clubs on college campuses (although now some high schools are joining in, as well), thus it is not surprising that 35 respondents (44.9% of the total sample) were involved with the organization once in college, while only 2 were involved during high school.

Also important to note here is the finding that nearly 45% of respondents are involved with *Active Minds* in college, while another 15 students (19.2%) are involved with a similar organization, *NAMI on Campus*. These seemingly high participation rates in mental health clubs are likely partially due to my study recruitment strategy, which included reaching out to Active Minds chapters at numerous colleges across the country. However, club membership may also indicate students' desire for a community of peer allies who share common interests – and often, lived experiences - and work together to mitigate stigma and educate classmates about mental health.

Table 6.7.3

*College mental health – Non-medical supports accessed & Campus-based Mental Health Orgs*

| | n | % who accessed informal MH supports in college (n=64) | % total (n=78) |
|---|---|---|---|
| Have accessed non-medical services, orgs, or other MH supports since beginning college | 64 | 100.0 | 82.1 |
| Specific supports accessed | | | |
| Active Minds | 35 | 54.7 | 44.9 |
| Social media sites related to MH | 20 | 31.3 | 25.6 |
| "NAMI on Campus" | 15 | 23.4 | 19.2 |
| Other | 15 | 23.4 | 19.2 |
| NAMI | 14 | 21.9 | 17.9 |
| Let's Erase the Stigma | 5 | 7.8 | 6.4 |
| Supported Education | 2 | 3.1 | 2.6 |
| Community "club house" | 1 | 1.6 | 1.3 |

| Does your college has a Mental Health Awareness or Advocacy Club? | n | % who have MH Club on campus (n=63) | % total (n=78) |
|---|---|---|---|
| Yes | 63 | 100.0 | 80.8 |
| No | 2 | | 25.6 |
| I Don't Know | 13 | | 16.7 |
| Ever been a member of this club? Yes | 39 | 61.9 | 50.0 |
| Currently a member of this club? Yes | 32 | 50.8 | 41.0 |

## Addressing RQ #2 Quantitatively: Mental Health Disclosures in High School and College

This next section of the chapter includes survey findings related to mental health disclosures in educational contexts. Disclosures to peers and school staff in high school are displayed, as well as particular recipients of disclosures, reasons for and against disclosing, and others' reactions to disclosures. Descriptive statistics are followed by paired samples t-tests to investigate changes in type and frequency of disclosures from high school to college, and, finally, linear regression is used to assess whether over-all level of disclosure in college can predict used of Student Disability Services and Counseling and Psychological Services on campus.

### General Level of Disclosure in High School and College

Tables 6.8.1 and 6.8.2 and Figures 6.4.1 and 6.4.2 present mean "High School Disclosure Computed" and "College Disclosure Computed" scores. These scores are aggregates of fifteen separate survey items, and I calculated them and utilize them here to represent generic level of disclosure in educational contexts ("No," "Low," "Moderate," "High," and "Very High"), without yet looking more deeply at exactly to whom and why certain disclosures are made.

The mean High School Disclosure Computed score is 7.96 on a 30-point scale, with a range of 24 and a standard deviation of 6.0. The mean College Disclosure Computed score is 13.44 on the same 30-point scale, with a range of 29 and a standard deviation of 5.8. As can be seen in Table 6.8.2, these two scores are positively, moderately, and significantly correlated. In addition, the means are significantly different, showing change in level of disclosure over time. Disclosure levels increase in college,

with more students disclosing, and more of them disclosing more broadly (to more people in their daily lives.)

Table 6.8.1

*Descriptive Statistics for Computed Disclosure Scores: High School vs. College*

Descriptive Statistics

| | N | Range | Min | Max | Mean | | Std. Deviation | Variance |
|---|---|---|---|---|---|---|---|---|
| | | | | | Statistic | Std. Error | | |
| HS DISC SCORE - COMPUTED | 78 | 24.00 | .00 | 24.00 | 7.9615 | .67972 | 6.00312 | 36.037 |
| COLL DISC - COMPUTED | 78 | 29.00 | 1.00 | 30.00 | 13.4359 | .66012 | 5.83004 | 33.989 |

*Note.* Both the High School and College Disclosure "Computed" scores are aggregates of 15 separate items from the survey. For the HS DISC - COMPUTED score, these items are: Q5-01, Q5-02, Q5-13 thru Q15, Q5-19, Q5-21 thru Q5-23, Q5-41 thru Q5-44, and Q5-46 – Q5-47. And for the COLL DISC – COMPUTED score, the items are: Q9-01, Q9-02, Q9-13, Q9-18 thru Q9-20, Q9-24, Q9-39 thru Q9-41, and Q9-44 thru Q9-45. (See Appendix L to review Survey).

The high possible for both HS and COLL DISC-COMP scores is "30," and the above table shows that scores at the HS level range from "0," meaning a respondent did not disclose to anyone, to a high of 24." College scores range from a low of "1," meaning that a respondent only disclosed to one person, to a high of "30," meaning that this respondent disclosed to virtually all of the people in his or her daily life.

The mean score on this measure for HS is 7.96, and for COLL it is 13.44. The difference in these over-all disclosure scores between high school and college is significant (see Table 6.8.2 for details).

Table 6.8.2

*Computed Disclosure Scores: High School vs. College*

*t*-Test

Paired Samples Statistics

| | Mean | N | Std. Deviation | Std. Error Mean |
|---|---|---|---|---|
| HS DISC SCORE - COMPUTED | 7.9615 | 78 | 6.00312 | .67972 |
| COLL DISC - COMPUTED | 13.4359 | 78 | 5.83004 | .66012 |

Paired Samples Correlations

| | N | Correlation | Sig. |
|---|---|---|---|
| HS DISC SCORE - COMPUTED & COLL DISC - COMPUTED | 78 | .260 | .022* |

Paired Samples Test

| | | Paired Differences | | | | | t | df | Sig, (2-tailed) |
|---|---|---|---|---|---|---|---|---|---|
| | | Mean | Std. Dev. | Std. Error Mean | 95% Confidence Interval of the Difference Lower | Upper | | | |
| Pair 1 | HS DISC SCORE - COMPUTED - COLL DISC - COMPUTED | -5.47436 | 7.19979 | .81522 | -7.098 | -3.851 | -6.715 | 77 | .000*** |

*Note.* The mean for the over-all computed disclosure (DISC) score in high school (HS) is 7.96, while the mean for the over-all computed disclosure score in college (COLL) is 13.44. These two means are weakly, positively, and significantly correlated (r = .260, p = .022). There is also a statistically significant difference between the two means ($t_{77}$ = 6.72, *p* = .000). On average, COLL computed disclosure scores are 5.47 points higher than HS computed disclosure scores (95% CI [-7.10, -3.85]).

*p < .05, ****p* < .001

Mean Computed Disclosure Scores: High School vs. College

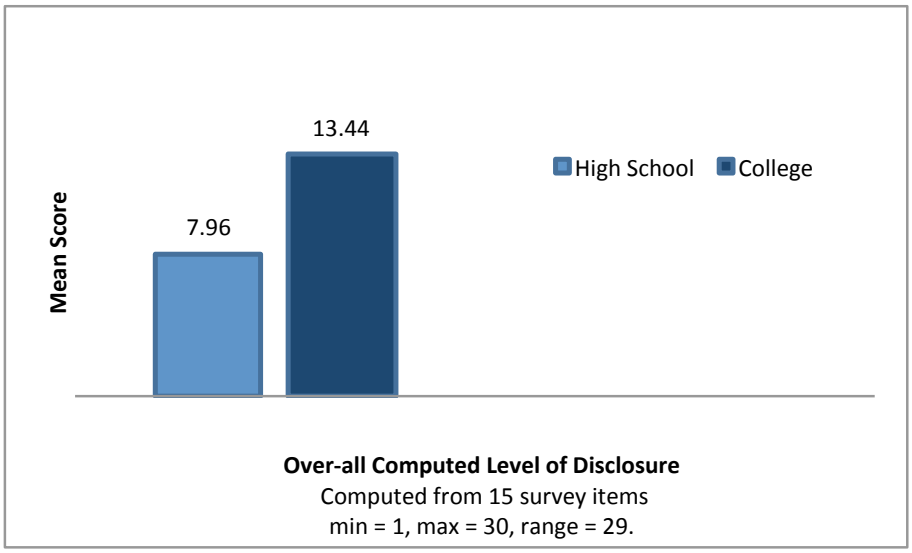



*Figure 6.4.1*. Both the High School and College Disclosure "Computed" scores are aggregates of 15 separate items from the survey. For the High School disclosure computed score (HS DISC – COMPUTED), these items are: Q5-01, Q5-02, Q5-13 thru Q15, Q5-19, Q5-21 thru Q5-23, Q5-41 thru Q5-44, and Q5-46 – Q5-47. And for the college computed disclosure score (COLL DISC – COMPUTED), the items are: Q9-01, Q9-02, Q9-13, Q9-18 thru Q9-20, Q9-24, Q9-39 thru Q9-41, and Q9-44 thru Q9-45.

The possible high score for both High School and College DISC-COMP scores is "30," and the above graph shows that the mean score on this measure for HS is 7.96, while the mean score for COLL it is 13.44. The difference in these over-all disclosure scores between high school and college is statistically significant (see Table 6.6.2 for details).

Changes in Disclosure Level from High School to College

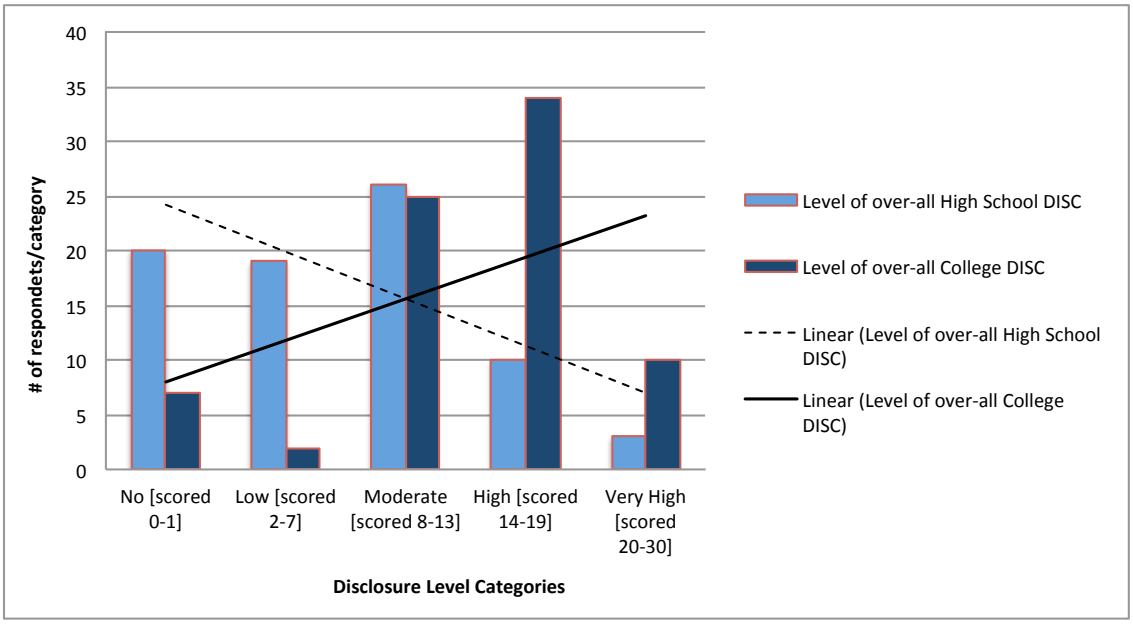



*Figure 6.4.2.* This bar graph shows frequencies for mean computed HS and COLL DISC scores organized categorically, by "No" disclosure, "Low" level of disclosure (scoring between 2 and 7 on the measure), "Moderate" (scoring between 8 and 13), "High" (scoring between 14 and 19), and "Very High" (scoring above "20") categories. The superimposed lines illustrate the trends: disclosures become more pervasive in college, as students are more likely to share elements of their mental health status or history with more people in their daily lives.

**Disclosures in High School.** In addition to computing levels of over-all disclosure, we can also go deeper with the survey data, investigating to *whom* respondents have made their mental health disclosures, *why* they have done this, and their perceptions of recipients' *reactions* to their disclosures. In this section of the chapter, I present some of these details.

Table 6.8.3 displays frequency and recipients (peer and faculty) of disclosures made in high school. Fifty-eight of the respondents (74.4%) disclosed some aspect of their mental health history or status to at least one peer or adult while in high school, while 20 respondents told no one. Among the 58 disclosers, 57 (98.3%) disclosed to peers, 36 (62.1%) disclosed to at least one school staff person *and* one peer, 20 (34.5%) disclosed *only* to peers, and 1 (1.3%) respondent disclosed *only* to a staff member (and not to any peers).

Regarding peer recipients of mental health disclosures in high school, 50 respondents (86,2% of the disclosers) shared some aspect of their mental illness with a "best friend," 35 (60.3%) told a boyfriend or girlfriend, and 31 (53.4%) shared with "certain classmates." The most common adult recipients of mental health disclosures in high school (32, 55.2%) are teachers and other *non*-mental health school professionals; the second most common recipients are school counselors, social workers, or psychologists (26, 44.8%). It is noteworthy that certain trusted teachers are more likely to receive mental health disclosures from students than are school counselors or other more formally trained mental health staff.

Table 6.8.3

*High School Disclosures - Frequency and Recipients*

| | n | % total sample (n=78) |
|---|---|---|
| **General disclosures during HS years** | | |
| Disc to most of the people in daily life | 7 | 9.0 |
| Selectively disc to certain people in daily life | 23 | 29.5 |
| Hardly disc to anyone in daily life | 28 | 38.5 |
| Did not disclose to anyone at all | 20 | 23.1 |
| **Students who disclosed to at least one adult *or* peer at school**[1] | **58** | **74.4** |
| **Students who did not disclose to anyone** | **20** | **25.6** |

| | n | % of disclosers (n=58) | % total sample (n=78) |
|---|---|---|---|
| **Recipients of disclosures in high school - overview** | | | |
| Disclosed to at least one peer[2] | 57 | 98.3 | 73.1 |
| Disclosed to at least one adult staff at school | 37 | 63.8 | 47.4 |
| Disclosed to at least one staff *and* one peer | 36 | 62.1 | 46.2 |
| Disclosed *only* to peers | 20 | 34.5 | 25.6 |
| Disclosed *only* to staff (and no peers)[3] | 1 | 1.7 | 1.3 |
| **Recipients of disclosures in high school - details** | | | |
| During HS, disclosed aspects of mental illness to *(check all that apply)* | | | |
| *In school – peers* | | | |
| my best friend | 50 | 86.2 | 64.1 |
| certain classmates at my school | 31 | 53.4 | 39.7 |
| my boy/girlfriend | 35 | 60.3 | 44.9 |
| members of team/band/club/or other school grp | 7 | 12.1 | 9.0 |
| all of my classmates at school | 3 | 5.2 | 3.8 |
| *In school – adults*[4] | | | |
| at least one teacher, coach, or other *non-MH* staff | 32 | 55.2 | 41.0 |
| at least one school counselor/social worker/psych | 26 | 44.8 | 33.3 |
| at least one teacher/other staff member *and* a counselor/social worker/psych | 18 | 31.0 | 23.1 |
| *only* to a teacher or other (non-MH) staff | 8 | 13.8 | 10.3 |
| *only* to a school counselor/social worker/psych | 7 | 12.1 | 9.0 |

[1]Note that almost ¾ of respondents *did* disclose to at least one person in high school about their mental illness, and this person was most likely to be a peer.
[2]Of the 58 total "disclosers" in high school, 57 disclosed to at least one peer.
[3]Only one respondent disclosed solely to an adult at school.
[4]Student disclosures regarding mental illness to adults in high school are more likely to occur to *teachers* or other non-mental health staff than they are to school counselors, social workers, or psychologists.

**Disclosures to Teachers and High School Staff.**

***Recipients.*** The following results are for the recipients of survey respondents' mental health disclosures, comparing recipients (peer and faculty) in high school to recipients in college. There is no significant difference between high school and college scores for disclosing to faculty or staff, but there is a significant difference in scores for disclosures to peers.

Also note that high school teachers are more likely to receive disclosures than high school mental health staff.

Frequencies of Faculty and School Staff Recipients of Disclosures: High School vs. College

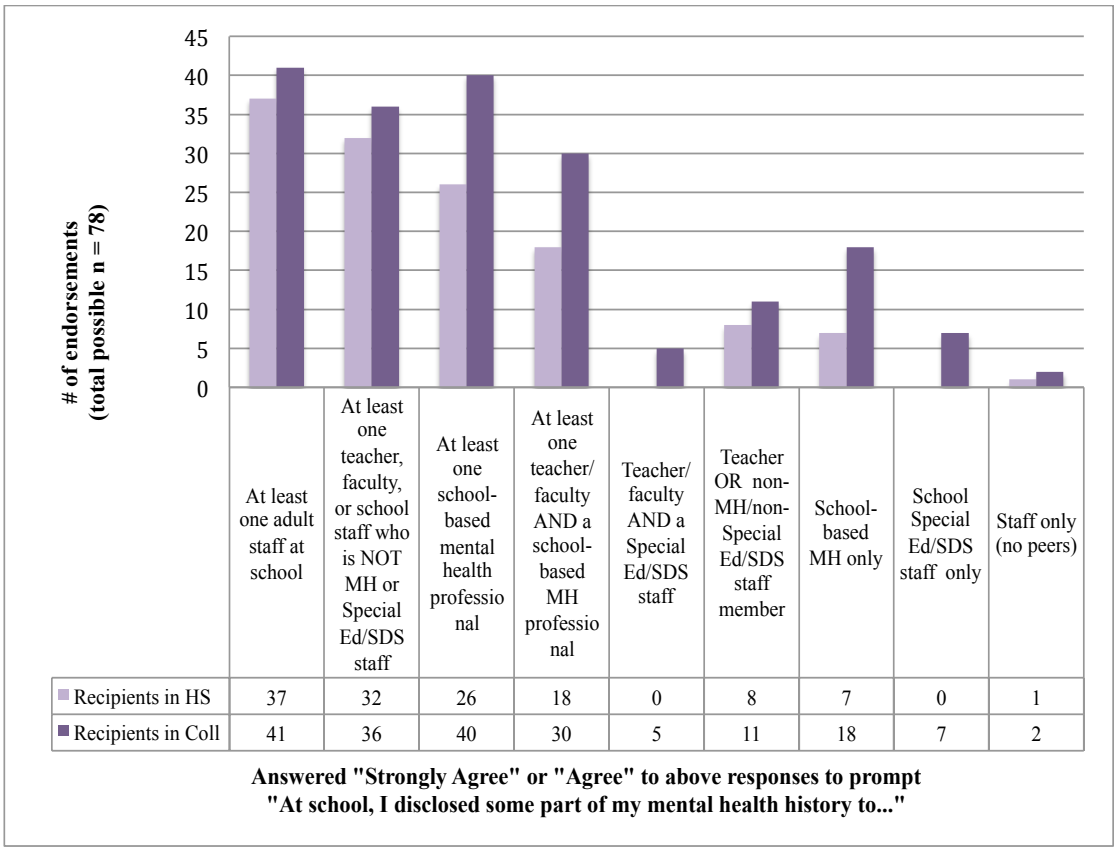



*Figure 6.4.3.* Frequency of endorsements in high school and college for various close-ended responses to the survey prompt "At school, I disclosed some part of my mental health history to…."

Table 6.8.4

*Peer and Faculty/Staff Disclosures: High School vs. College*

(Pair 1: survey questions Q5-02 and Q9-02; Pair 2: survey questions Q5-13 and Q9-13)

Paired Samples Statistics

| | | Mean | N | Std. Deviation | Std. Error Mean |
|---|---|---|---|---|---|
| Pair 1 | I disclosed my MI to certain teachers or other adults at my HS. | 1.46 | 57 | .503 | .067 |
| | I disclosed my MI to certain faculty or other staff at my college. | 1.44 | 57 | .501 | .066 |
| Pair 2 | I disclosed my MI to certain classmates at my college. | 1.12 | 57 | .331 | .044 |
| | I disclosed my MI to certain classmates at my HS. | 1.49 | 57 | .504 | .067 |

Paired Samples Correlations

| | | N | Correlation | Sig. |
|---|---|---|---|---|
| Pair 1 | I disclosed my MI to certain teachers or other adults at my HS. & I disclosed my MI experience to certain faculty or other staff at my college. | 57 | .255 | .055 |
| Pair 2 | I have disclosed my MI to certain classmates at my college & I disclosed my MI to certain classmates at my HS. | 57 | .167 | .215 |

Paired Samples Test

| | | Paired Differences | | | | | t | df | Sig. (2-tailed) |
|---|---|---|---|---|---|---|---|---|---|
| | | Mean | Std. Dev | Std. Error Mean | 95% Confidence Interval of the Difference Lower | Upper | | | |
| Pair 1 | I disclosed my MI to certain teachers or other adults at my HS. - I disclosed some of my MI to certain faculty or other staff at my college. | .018 | .612 | .081 | -.145 | .180 | .216 | 56 | .829 |
| Pair 2 | I disclosed my MI to certain classmates at my college - I disclosed my MI to certain classmates at my HS. | .368 | .555 | .074 | .516 | .221 | 5.01 | 56 | .000*** |

High School and College disclosures to school faculty or staff are weakly and positively correlated, (r = .255), but the correlation is not significant (*p* is .055). High School and College disclosures to classmates and peers are weakly and positively correlated (r = .167), but the correlation is not significant (*p* is .215). There is no significant difference between High School and College mean scores for disclosing to faculty or staff ($t_{56}$ = .216, *p* is .829) and (95% CI [-.15, .18]).

There is a significant difference between High School and College mean scores for disclosing to classmates ($t_{56}$ = 5.01, *p* is .000). The average College score for disclosing to peers is .37 points higher than the average High School score (95% CI [.22, .51]) when "Yes" to disclosing is 2 points, and "No" is 1 point.

****p* < .001

In addition to the above, Figure 6.4.4 and Table 6.8.5, below show that there is a significant difference in mean scores for disclosing to "one trusted teacher" (as opposed to faculty in general) in high school versus college, with the score significantly higher in high school.

Faculty and School Staff Recipients of Disclosures: Mean scores in High School vs. College

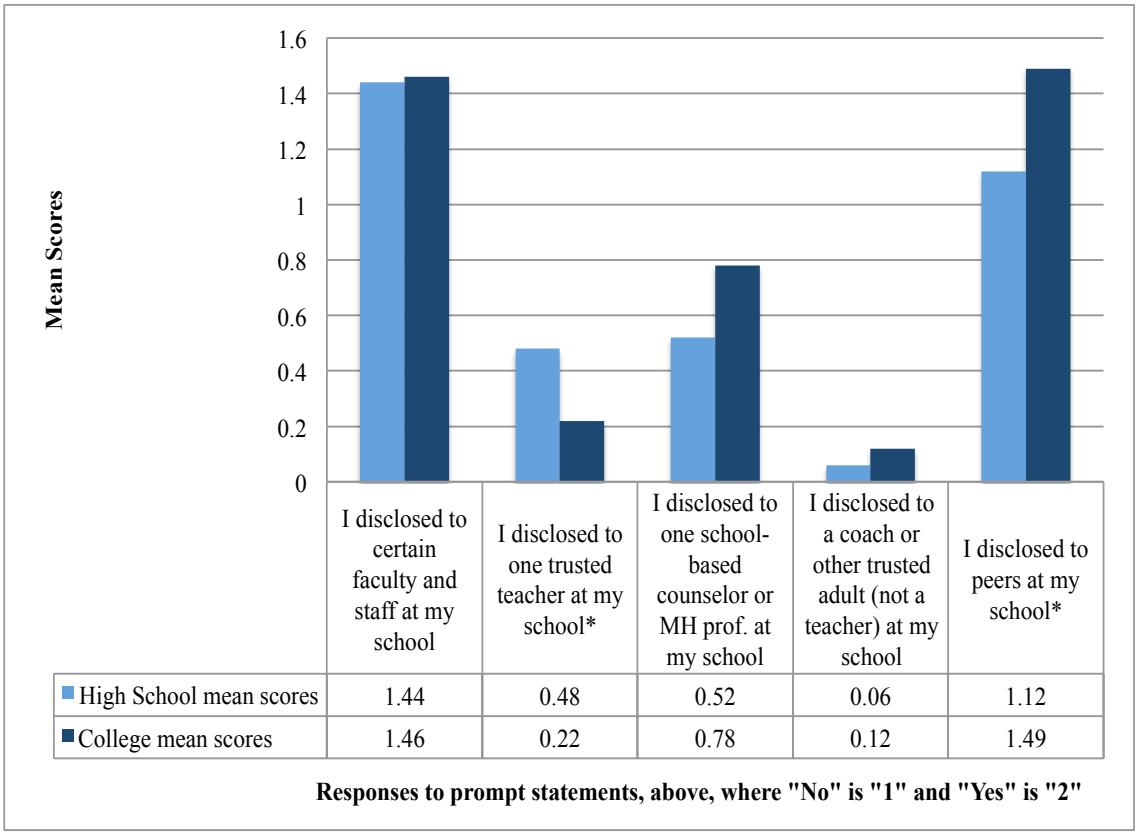



*Figure 6.4.4*. Mean differences in high school versus college endorsements of the above statements regarding mental health disclosures at school. Note that both "I disclosed to one trusted teacher at my school" and "I disclosed to peers at my school" show significant differences in means. (Paired sampled t-test results for these two pairs of responses are presented in Tables 6.8.4 and 6.8.5.) More participants disclosed to "one trusted teacher" in high school than in college, but more participants disclosed to "peers at my school" in college than in high school.

Table 6.8.5

*Significant Difference in Mean Disclosures to "a trusted teacher/faculty member" in High School vs. College* (survey questions Q5-56-10 and Q9-44-9)

t-Test

Paired Samples Statistics

| | | Mean | N | Std. Deviation | Std. Error Mean |
|---|---|---|---|---|---|
| Pair 1 | People to whom I disclosed in HS:-One trusted teacher . | .22 | 23 | .422 | .088 |
| | People to whom I have disclosed in college:- One trusted faculty member. | .48 | 23 | .511 | .106 |

Paired Samples Correlations

| | | N | Correlation | Sig. |
|---|---|---|---|---|
| Pair 1 | People to whom I disclosed in HS: -One trusted teacher. & People to whom I have disclosed college: -One trusted faculty member. | 23 | .550 | .006** |

Paired Differences

| | | Mean | Std. Deviation | Std. Error Mean | 95% Confidence Interval of the Difference | | t | df | Sig. (2-tailed) |
|---|---|---|---|---|---|---|---|---|---|
| | | | | | Lower | Upper | | | |
| Pair 1 | People to whom I disclosed in HS:-One trusted teacher. - People to whom I have disclosed in college:- One trusted faculty member. | -.261 | .449 | .094 | -.455 | -.067 | -2.787 | 22 | .011* |

High School (HS) and College disclosures to "a trusted teacher/faculty member" are positively, strongly, and significantly correlated. r = .550, p = .006. There is also a significant difference in the HS and College mean scores for disclosures to "A trusted teacher/faculty member" ($t_{22}$ = 2.787, p = .011). On average, college scores for this type of disclosure are .26 points higher than HS scores for this type of disclosure, where "1" is a "Yes" to disclosure and "2" is a "No" to disclosure (95% CI [ -.455, -.067]), meaning that disclosures of this kind are actually less likely in college than they are in HS.

* p < .05, ** p < .01

***Reasons for disclosing to faculty and school staff.*** The following results are reasons that survey respondents endorsed for making mental health disclosures to faculty in high school versus in college. General results are displayed in Table 6.8.6. Figure 6.4.5 shows that one of the reasons, "to get help with assignments if I had to miss class because of my mental illness" is significantly different, with more endorsements in college than in high school. (See Table 6.8.8 for the paired samples *t*-test showing this significant mean difference.)

Figure 6.4.6 organizes the reasons for disclosing to faculty into three broad categories: Relational reasons, Academic reasons, and "Only when I could no longer hide it," showing frequencies for these. Academic reasons are the most common endorsements at both the high school and college level, with a trend of more disclosures in college. In addition, there are fewer instances of disclosing to faculty "only when [students] could no longer hide" their mental illnesses in college.

Table 6.8.6

*Disclosures to high school staff - Reasons for and Reactions to*

| *For respondents who disclosed to school staff* | n | % who disclosed to school staff (n=37) | % who disclosed to anyone (n=58) | % total sample (n=78) |
|---|---|---|---|---|
| **Reasons to disclose to HS teachers or staff** *(Responded "Strongly Agree" or "Agree" to the following items)*[1] | | | | |
| *Academic reasons* | | | | |
| to access formal services and academic accomms | 21 | 56.8 | 36.2 | 26.9 |
| to get help with assignments if I had to miss school | 22 | 59.5 | 37.9 | 28.2 |
| *Relational reasons* | | | | |
| so teachers could understand me better | 23 | 62.2 | 39.7 | 29.5 |
| only when it was so obvious I could not hide it (e.g. after a hospitalization and return to school) | 24 | 64.9 | 41.4 | 30.7 |
| **Reactions to student's disclosure(s) by HS teachers or staff** *"When I disclosed some of my mental illness experience in HS, teachers and school staff…" (Responded "Strongly Agree" or "Agree" to the following items)* | | | | |
| *Positive reactions* | | | | |
| listened respectfully | 27 | 73.0 | 46.6 | 34.6 |
| understood me | 27 | 73.0 | 46.6 | 34.6 |
| accepted me | 25 | 67.6 | 43.1 | 32.1 |
| treated me better afterwards | 10 | 27.0 | 17.2 | 12.8 |
| *Negative reactions* | | | | |
| seemed uncomfortable | 10 | 27.0 | 17.2 | 12.8 |
| treated me worse afterwards | 5 | 13.5 | 8.6 | 6.4 |
| *Neutral reaction* | | | | |
| treated me the same afterwards | 20 | 54.1 | 34.5 | 25.6 |

[1]*Note*. Survey participants chose among responses on a 5-point Likert scale: "Strongly Agree" [5], "Agree" [2], "Not Sure" [3], "Disagree" [2], and "Strongly Disagree" [1].
"accomms," above is abbreviation for "accommodations"

Reasons to Disclose to Faculty & Staff: High School vs. College

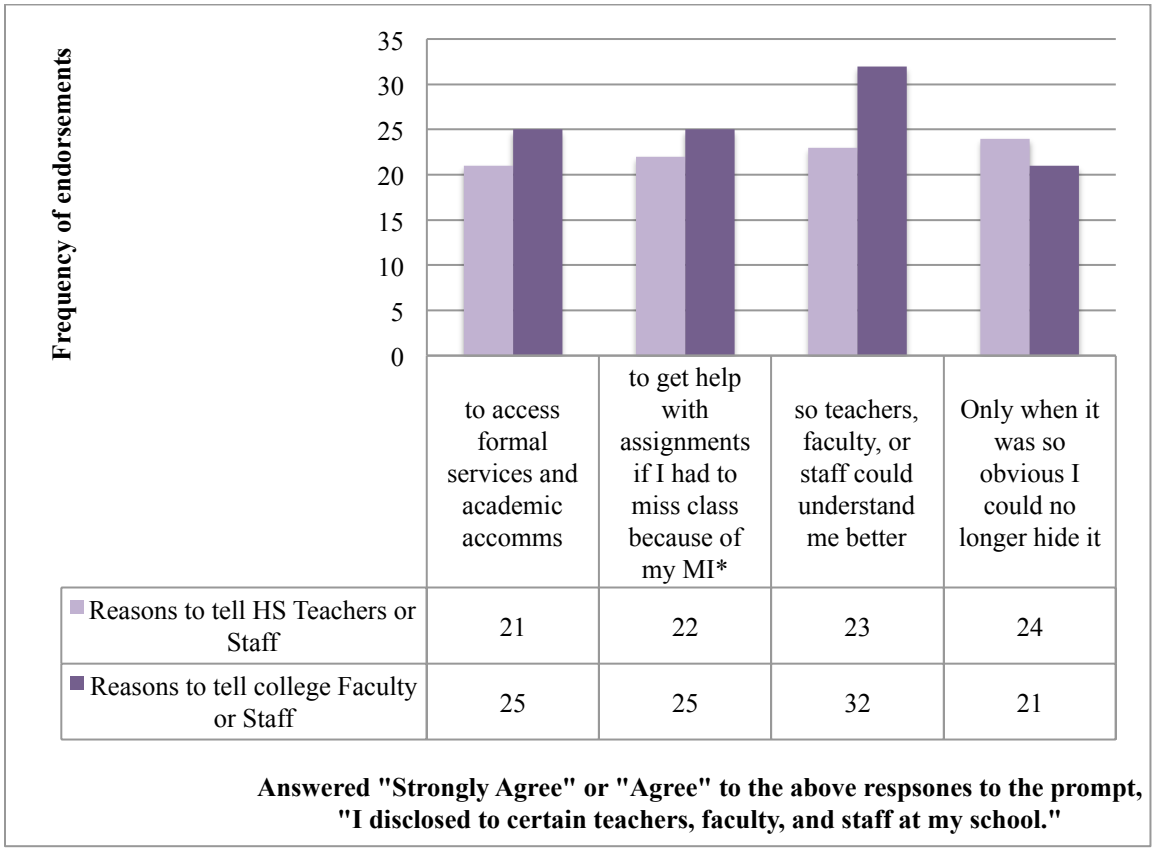



*Fig. 6.4.5*. This bar chart displays frequencies for endorsements of certain close-ended responses to the prompt "I disclosed to certain teachers, faculty, and staff at my school..." Respondents who endorsed the above statements with "Strongly Agree" or "Agree" (on a 5-point Likert scale where "Strongly Agree" was 5 and "Strongly Disagree" was 1) are included in the chart.

From left to right, above, responses to the following survey questions are included regarding high school and college: Q5-03 and Q9-03; Q5-04 an Q9-05; Q5-05 and Q9-04; and Q5-25 and Q9-24. In addition,"to get help with assignments if I had to miss class

because of my mental illness”* shows a significant difference in means between high school and college (see Table 6.8.8 for details).

Table 6.8.7

*No Significant Difference in Mean scores for Disclosing to faculty "in order to access formal services and academic accommodations"*

*t*- Test

Paired Samples Statistics

| | | Mean | N | Std. Deviation | Std. Error Mean |
|---|---|---|---|---|---|
| | I disclosed some of my MI experience to teachers or other adults at my HS to access formal services and academic accommodations | 3.48 | 21 | 1.436 | .313 |
| | I disclosed some of my MI experience to faculty or other staff at my college in order to access formal services and academic accommodations | 3.67 | 21 | 1.560 | .340 |

Paired Samples Correlations

| | | N | Correlation | Sig. |
|---|---|---|---|---|
| | I disclosed…in HS in order to access formal services and academic accommodations & I disclosed…in college in order to access formal services and academic accommodations | 21 | .052 | .823 |

Paired Samples Test

| | | Paired Differences | | | | | t | df |
|---|---|---|---|---|---|---|---|---|
| | | Mean | Std. Deviation | Std. Error Mean | 95% Confidence Interval of the Difference Lower | Upper | | |
| Pair 1 | I disclosed some of my MI experience to teachers or other adults at my HS in order to access formal services and academic accommodations. - I disclosed some of my MI experience to faculty or other staff at my college in order to access formal services and academic accommodations | -.190 | 2.064 | .450 | -1.130 | .749 | -.423 | 20 |

*$p < .05$

Table 6.8.8

*Significant Difference in Mean Scores for Disclosing to Faculty "in order to get help with schoolwork if had to miss class because of mental illness"*

t-Test

Paired Samples Statistics

| | Mean | N | Std. Deviation | Std. Error Mean |
|---|---|---|---|---|
| I disclosed some of my MI experience to teachers and other adults at my HS so they could help me with schoolwork if I needed support or had to miss school because of my illness. | 3.19 | 21 | 1.327 | .290 |
| I disclosed some of my MI experience to faculty and other staff at my college so they help me with schoolwork if I needed support or had to miss school because of my illness. | 3.86 | 21 | 1.195 | .261 |

Paired Samples Correlations

| | N | Correlation | Sig. |
|---|---|---|---|
| I disclosed…to teachers and other adults at my HS so they could... & I disclosed….faculty and other staff at my college so they could... | 21 | .585 | .005** |

Paired Samples Test

| | Paired Differences | | | | | t | df | Sig. (2-tailed) |
|---|---|---|---|---|---|---|---|---|
| | Mean | Std. Deviation | Std. Error Mean | 95% Confidence Interval of the Difference Lower | Upper | | | |
| I disclosed…to teachers and other adults at my high schools... - I disclosed…. to faculty and other staff at my college so they... | -.667 | 1.155 | .252 | -1.192 | -.141 | -2.646 | 20 | .016* |

* p < .05, ** p < .01

Table 6.8.9

No Significant Difference in Mean scores for Disclosing "so teachers, faculty, or staff could understand me better."

*t*-Test

Paired Samples Statistics

| | | Mean | N | Std. Deviation | Std. Error Mean |
|---|---|---|---|---|---|
| Pair 1 | I disclosed some of my MI experience to teachers and other adults at my HS so they could understand me better. | 3.71 | 21 | 1.419 | .310 |
| | I disclosed some of my MI experience to faculty and other staff at my college so they could understand me better. | 4.10 | 21 | .995 | .217 |

Paired Samples Correlations

| | | N | Correlation | Sig. |
|---|---|---|---|---|
| Pair 1 | I disclosed….in HS so they could understand me better. & I disclosed…in college so they could understand me better. | 21 | .445 | .043* |

| | | Paired Differences | | | | | t | df | Sig. (2-tailed) |
|---|---|---|---|---|---|---|---|---|---|
| | | Mean | Std. Deviation | Std. Error Mean | 95% Confidence Interval of the Difference Lower | Upper | | | |
| Pair 1 | I disclosed…in HS so they could understand me better. - I disclosed…in college so they could understand me better, | -.381 | 1.322 | .288 | -.983 | .221 | -1.321 | 20 | .202 |

*$p < .05$

Table 6.8.10

*No Significant Difference in Mean scores for Disclosing "only when it was so obvious I could no longer hide it."*

*t*-Test

Paired Samples Statistics

| | | Mean | N | Std. Deviation | Std. Error Mean |
|---|---|---|---|---|---|
| Pair 1 | When I was in HS, I disclosed some of my MI experience only when…. | 2.89 | 57 | 1.319 | .175 |
| | In college, I have disclosed some of my MI experience only when … | 2.74 | 57 | 1.247 | .165 |

Paired Samples Correlations

| | | N | Correlation | Sig. |
|---|---|---|---|---|
| Pair 1 | When I was in HS, I disclosed some of my MI experience only when… & In college, I have disclosed some of my MI experience only… | 57 | .059 | .664 |

Paired Samples Test

| | | Paired Differences | | | | | t | df | Sig. (2-tailed) |
|---|---|---|---|---|---|---|---|---|---|
| | | Mean | Std. Deviation | Std. Error Mean | 95% Confidence Interval of the Difference Lower | Upper | | | |
| Pair 1 | When I was in HS, I disclosed some of my MI experience only when… - In college, I have disclosed some of my MI experience only when .... | .158 | 1.761 | .233 | -.309 | .625 | .677 | 56 | .501 |

* p < .05

Reasons to Disclose to Faculty & Staff in High School vs. College: Categories

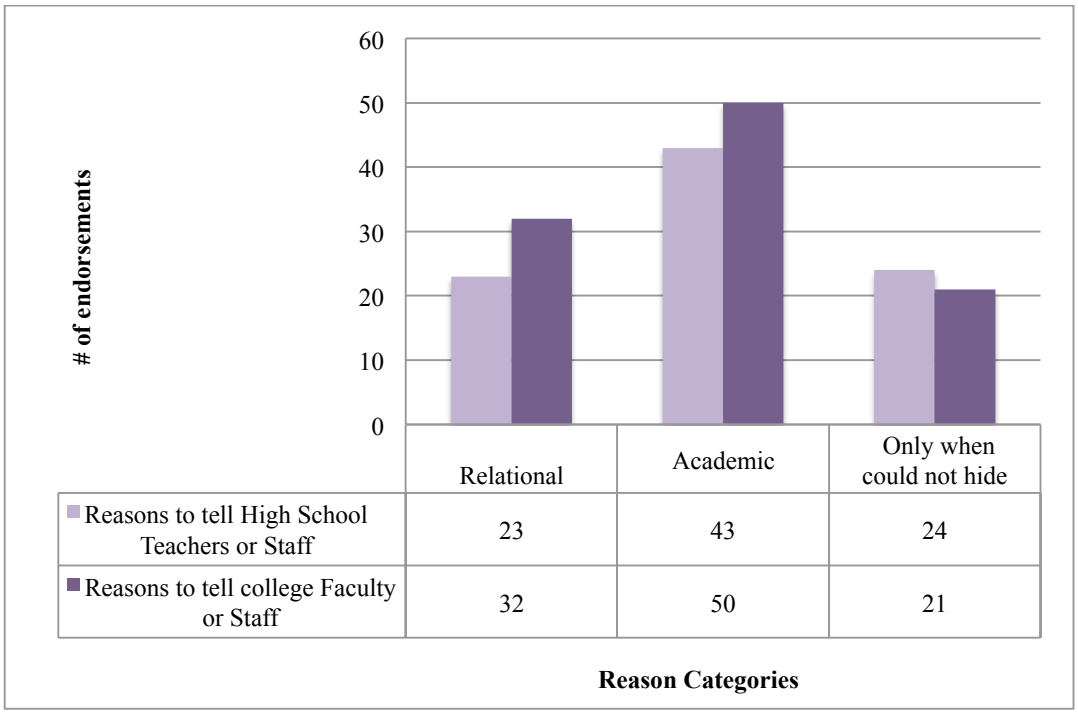



*Figure 6.4.6.* This bar chart depicts multiple-choice responses within each category (*Relational*, *Academic*, and *Only when could not hide*) to the prompt "I disclosed to certain teachers and/or staff at school…"

The *Relational* reason option to disclose is "so they could understand me better"; the *Academic* reasons are "to access formal services and academic accommodations" and "to get help with course work if I had to miss class because of my mental illness."

Note that the three categories, above, were created after survey data was collected; the survey respondents had 4 choices from which to select, and were asked to "please choose all that apply."

***Reactions from faculty and school staff to disclosures.*** The following tables and figures display students' perceptions of school faculty and staff reactions to their (the students') mental health disclosures. Figure 6.4.7 shows frequencies for types of reactions, while Tables 6.8.11 through 6.8.15 show the results of paired samples t-tests for mean differences in faculty reactions to disclosures in high school versus college. Three reactions ("accepted me," "seemed uncomfortable," and "treated me better afterwards") have means that are significantly different. Students feel more "accepted" by college faculty after disclosing some aspect of their mental illness; high school faculty seemed more "uncomfortable" after receiving mental health disclosures; and high school faculty treated students "better" after a disclosure than did college faculty. This last significant finding may seem surprising; however, it could be due to the fact that college faculty were already treating students relatively well, while the high school teachers and staff had more room for improvement.

Figures 6.4.8, 6.4.9, and 6.4.10 are bar charts depicting the three significant mean differences in reactions to disclosures described above.

Type and Frequency of Faculty and Staff Reactions to Disclosures: High School vs. College

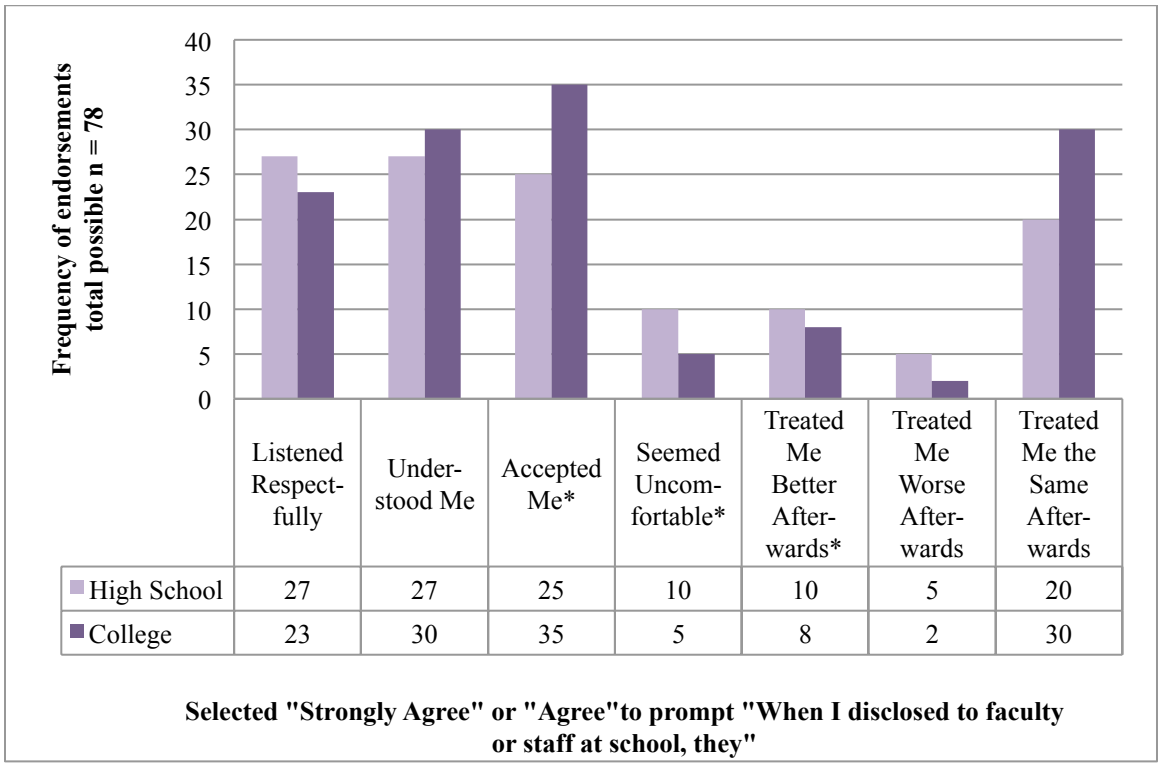



*Figure 6.4.7.* This bar chart displays frequencies representing changes in school faculty and staff *reactions* to survey respondents' disclosures in high school versus college. Note that a total of 37 students disclosed to teachers or other staff in high school, while 41 disclosed to faculty or campus staff in college (See Figure 6.4.3). In general, students seem to have had more positive reactions to their disclosures in college. For example, 27 (73.0% of the 37) students reported feeling "understood" and 25 (67.6%) reported feeling "accepted" in high school, while 30 (73.2% of the 41 college disclosers) reported feeling "understood" by faculty and 35 (85.4%) reported feeling "accepted" by them.

The only exceptions to the general trend of improved reactions from faculty to disclosures are (1) the far-left pair of bars, depicting students' perceptions that high

school teachers and staff "listened respectfully" when receiving students' disclosures more often than did college faculty and staff, and (2) the "Treated Me Better Afterwards" pair of bars.

Also note that the following mean changes over time are significant: (1) "Accepted Me"; (2) "Seemed Uncomfortable"; and (3) "Treated Me Better" afterwards. Related statistics for these mean differences are presented in Tables 6.8.13, 6.8.14 and 6.8.15.

Table 6.8.11

*No Significant Mean Difference in "Listened Respectfully" Faculty/Staff Reactions to Disclosures: High School vs. College*

*t*-test

Paired Samples Statistics

| | Mean | N | Std. Deviation | Std. Error Mean |
|---|---|---|---|---|
| When I disclosed some of my MI experience in HS, teachers and school staff listened respectfully. | 3.95 | 19 | 1.026 | .235 |
| In college, when I disclosed some of my MI experience, faculty and campus staff listened respectfully. | 4.47 | 19 | .841 | .193 |

Paired Samples Correlations

| | N | Correlation | Sig. |
|---|---|---|---|
| ….in HS, teachers and school staff listened respectfully & In college…faculty and campus staff listened respectfully. | 19 | .159 | .515 |

Paired Samples Test

| | Paired Differences | | | | | t | df | Sig. (2-tailed) |
|---|---|---|---|---|---|---|---|---|
| | Mean | Std. Deviation | Std. Error Mean | 95% Confidence Interval of the Difference Lower | Upper | | | |
| …in HS…teachers and school staff listened respectfully - In college….faculty and campus staff listened respectfully. | -.526 | 1.219 | .280 | -1.114 | .061 | -1.882 | 18 | .076 |

*Note*. High School (HS) and College experiences of school faculty and staff "listening respectfully" (survey questions Q5-06 and Q9-06) when survey respondents disclosed personal information about mental illness (MI) related not significantly correlated (r = .159, p is .515). In addition, there is no significant difference in means between HS and College experiences of feeling that school staff listened "respectfully" if respondents disclosed to them ($t_{18}$ = 1.88, p is .076). The average HS score for feeling listened to respectfully is approximately .5 points higher than the average college score on a scale where "1" is "Strongly Disagree" and "5" is "Strongly Agree." But, again, this difference is not significant.

Table 6.8.12

*No Significant Difference in Mean "UNDERSTOOD ME" Faculty/Staff Reactions to Disclosures: High School vs. College*

*t*-test

Paired Samples Statistics

| | | Mean | N | Std. Deviation | Std. Error Mean |
|---|---|---|---|---|---|
| | When I disclosed some of my MI experience in HS, teachers and school staff understood me, | 3.75 | 20 | .851 | .190 |
| | In college, when I have disclosed some of my MI experience, faculty and school staff understood me. | 4.25 | 20 | .639 | .143 |

Paired Samples Correlations

| | | N | Correlation | Sig. |
|---|---|---|---|---|
| | When I disclosed some of my MI experience in HS teachers and school staff understood me & In college, when I have disclosed some of my MI experience, faculty and campus staff understood me. | 20 | -.073 | .761 |

Paired Samples Test

| | | Paired Differences | | | | | t | df | Sig. (2-tailed) |
|---|---|---|---|---|---|---|---|---|---|
| | | Mean | Std. Deviation | Std. Error Mean | 95% Confidence Interval of the Difference Lower | Upper | | | |
| Pair 1 | When I disclosed some of my MI experience in HS, teachers and school staff understood me. - In college, when I have disclosed some of my MI experience, faculty and campus staff understood me. | -.500 | 1.100 | .246 | -1.015 | .015 | -2.032 | 19 | .056 |

*Note*. High School (HS) and College experiences of survey respondents feeling that school faculty and staff "understood" them (survey questions Q5-07 and Q9-07) when they disclosed certain personal mental illness (MI) information are not significantly correlated (r = -.073, *p* is .761). In addition, there is no significant difference in means between HS and College experiences of feeling "understood" by school faculty/ staff after disclosing to them ($t_{19}$ = 2.03, p is .056). The average HS score for feeling "understood" is .5 points lower than the average college score on a scale where "1" is "Strongly Disagree" and "5" is "Strongly Agree." But, again, this difference is not significant.

Table 6.8.13

*Significant Difference in Mean "Accepted Me" Faculty/Staff Reaction to Disclosures: HS vs. College*

*t*-test

Paired Samples Statistics

| | Mean | N | Std. Deviation | Std. Error Mean |
|---|---|---|---|---|
| In HS when I disclosed some of my MI experience, teachers and school staff accepted me. | 3.55 | 20 | 1.146 | .256 |
| In college, when I have disclosed some of my MI experience, faculty and campus staff accepted me. | 4.35 | 20 | .671 | .150 |

Paired Samples Correlations

| | N | Correlation | Sig. |
|---|---|---|---|
| In HS…teachers and school staff accepted me. & In college…faculty and school staff accepted me. | 20 | .353 | .127 |

Paired Samples Test

| | Paired Differences | | | | | t | df | Sig. (2-tailed) |
|---|---|---|---|---|---|---|---|---|
| | Mean | Std. Deviation | Std. Error Mean | 95% Confidence Interval of the Difference Lower | Upper | | | |
| In HS…teachers and school staff accepted me. - In college…faculty and campus staff accepted me. | -.800 | 1.105 | .247 | -1.317 | -.283 | -3.238 | 19 | .004* |

*Note*. High School (HS) and College experiences of survey respondents feeling that school faculty and staff "accepted" them (survey questions Q5-08 and Q9-08) when they disclosed certain personal mental illness (MI) related information are not significantly correlated (r = .353, p is .127). There is a significant difference in means between HS and College experiences of feeling "accepted" by school faculty and staff after disclosing to them ($t_{19}$ = 3.24, p < .01). The average HS score for feeling "accepted" is .8 points *lower* than the average college score on a scale where "1" is "Strongly Disagree" and "5" is "Strongly Agree" (95% CI [ -1.32, -.28]). We can interpret this as meaning that, on average, survey respondents have felt "accepted" more by college faculty and staff when disclosing mental illness-related information to them than they did when disclosing to their high school teachers and secondary school staff.

** p < .01

Significant Difference in Mean Scores for Faculty/Staff Reactions of "Accepted Me" to Disclosures in HS vs. College

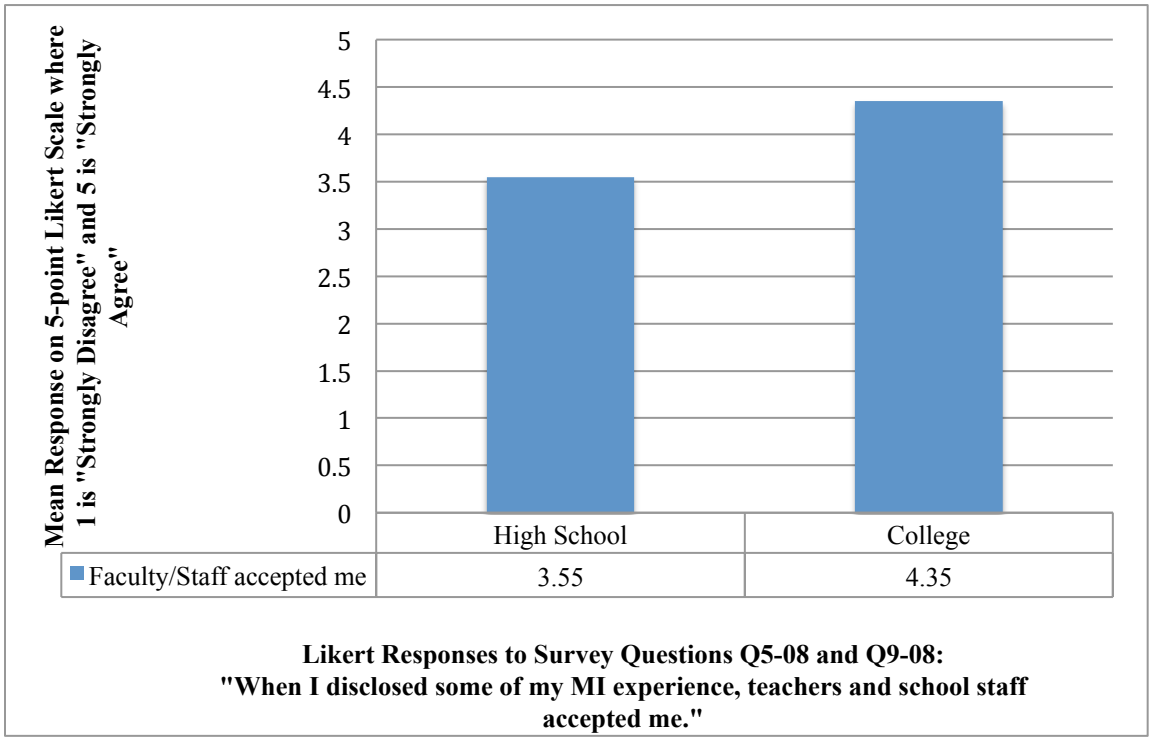



*Figure 6.4.8.* Mean difference values representing instances of survey respondents feeling "accepted" by school faculty or staff after making a mental health-related disclosure to them. When prompted with the statement "When I disclosed some of my MI (mental illness) experience, teachers and school staff accepted me," respondents were asked to choose a response from among the following: "Strongly Disagree" [1], "Disagree" [2], "Not Sure" [3], "Agree' [4], or "Strongly Agree" [5]. The mean responses, as shown in this graph, are 3.55 (between "Not Sure" and "Agree") in high school, and 4.35 (between "Agree" and "Strongly Agree" in college.) This change in responses from high school to college is significant ($t_{19} = 3.24$, $p < .01$). The average HS

score for feeling "accepted" is .8 points lower than the average college score. See Table 6.6.9 for details on the paired samples t-test performed.

Table 6.8.14
*Significant Difference in Mean "Seemed Uncomfortable" Faculty-Staff Reactions to Disclosures: HS vs. College*

*t*-test

Paired Samples Statistics

| | | Mean | N | Std. Deviation | Std. Error Mean |
|---|---|---|---|---|---|
| | In HS, when I disclosed some of my MI experience, teachers and school staff seemed uncomfortable. | 3.14 | 21 | .964 | .210 |
| | In college, when I have disclosed some of my MI experience, faculty and campus staff seemed uncomfortable. | 1.95 | 21 | .973 | .212 |

Paired Samples Correlations

| | | N | Correlation | Sig. |
|---|---|---|---|---|
| | In HS when I disclosed some of my MI experience, teachers and school staff seemed uncomfortable. & In college, when I have disclosed some of my MI experience, faculty and campus staff seemed uncomfortable. | 21 | .487 | .025* |

Paired Samples Test

| | | Paired Differences | | | | | t | df | Sig. (2-tailed) |
|---|---|---|---|---|---|---|---|---|---|
| | | Mean | Std. Deviation | Std. Error Mean | 95% Confidence Interval of the Difference Lower | Upper | | | |
| Pair 1 | in HS…teachers and school staff seemed uncomfortable - In college…faculty and campus staff seemed uncomfortable. | 1.190 | .981 | .214 | .744 | 1.637 | 5.562 | 20 | .000** |

*Note*. High School (HS) and College experiences of survey respondents feeling that school faculty and staff "seemed uncomfortable" (survey questions Q5-09 and Q9-09) when they disclosed certain personal mental illness (MI) related information are moderately to strongly positively, and significantly correlated ($r = .487$, $p < .05$). In addition, there is a significant difference in means between HS and College experiences of sensing that school faculty and staff "seemed uncomfortable" after disclosing to them

($t_{20} = 5.56$, $p < .001$). The average HS score for feeling that school faculty and staff "seemed uncomfortable" is 1.19 points higher than the average college score on a scale where "1" is "Strongly Disagree" and "5" is "Strongly Agree" with the statement. We can interpret this as meaning that, on average, the survey respondents feel that college faculty and staff have seemed more comfortable when receiving students' mental illness-related disclosures than did the students' high school teachers and secondary school staff.

* $p < .05$, ** $p < .001$

Significant Difference in Mean Scores for Faculty/Staff Reactions of "Seemed Uncomfortable" to Disclosures in HS vs. College

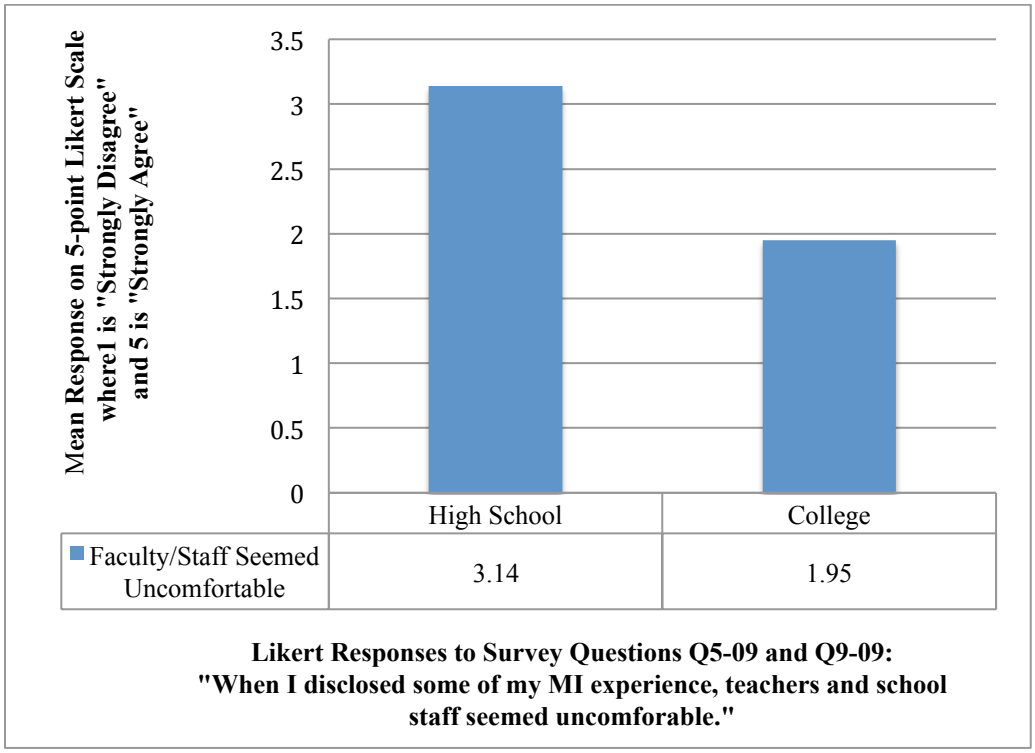



*Figure 6.4.9.* Mean difference values representing instances of survey respondents feeling that school faculty or staff "seemed uncomfortable" after receiving a mental health-related disclosure from them. When prompted with the statement "When I disclosed some of my MI (mental illness) experience, teachers and school staff seemed uncomfortable," respondents were asked to choose a response from among the following: "Strongly Disagree" [1], "Disagree" [2], "Not Sure" [3], "Agree' [4], or "Strongly Agree" [5]. The mean responses, as shown in this graph, are 3.14 ("Not Sure") in high school, and 1.95 ("Disagree" and "Strongly Disagree" in college.) This change in

responses from high school to college is significant ($t_{20} = 5.56$, $p < .001$). See Table 6.6.10 for details on the paired samples t-test performed, and outcomes.

Table 6.8.15

*Significant Difference in Mean "Treated Me Better Afterwards" Faculty/Staff Reactions to Disclosures: HS vs. College*

*t*-test

Paired Samples Statistics

| | Mean | N | Std. Deviation | Std. Error Mean |
|---|---|---|---|---|
| In HS when I disclosed some of my MI experience, teachers and school staff treated me better afterwards. | 2.24 | 21 | 1.179 | .257 |
| In college, when I have disclosed some of my MI experience, faculty and campus staff treated me better afterwards. | 1.71 | 21 | .784 | .171 |

Paired Samples Correlations

| | N | Correlation | Sig. |
|---|---|---|---|
| In HS….teachers and school staff treated me better afterwards. & In college….faculty and campus staff treated me better afterwards. | 21 | .564 | .008** |

Paired Samples Test

| | Paired Differences | | | | | t | df | Sig. (2-tailed) |
|---|---|---|---|---|---|---|---|---|
| | Mean | Std. Deviation | Std. Error Mean | 95% Confidence Interval of the Difference Lower | Upper | | | |
| In HS…. teachers and school staff treated me better afterwards. - In college…faculty and campus staff treated me better afterwards. | .524 | .981 | .214 | .077 | .970 | 2.447 | 20 | .024* |

*Note*. High School (HS) and College experiences of survey respondents feeling that they were "treated better" by school faculty and staff (survey questions Q5-10 and Q9-10) after disclosing certain personal mental illness (MI) related information are strongly, positively, and significantly correlated ($r = .564$, $p < .01$). In addition, there is a

significant difference in means between HS and College experiences of feeling "treated better" by school faculty and staff after disclosing to them ($t_{20} = 2.45$, $p < .005$). The average HS score for feeling "treated better" after disclosing to school faculty and staff is .524 points higher than the average College score on a scale where "1" is "Strongly Disagree" and "5" is "Strongly Agree" with the statement.

We can interpret this as meaning that, on average, more survey respondents felt that secondary school teachers and staff treated them better after receiving mental health disclosures than did college faculty and staff. It is important to note, however, that this finding does not necessarily mean that college faculty and staff did not treat students as well as high school teachers or staff; the finding could, in fact, imply that college faculty and staff were *already* treating survey respondents fairly well, thus there was less room for improved interactions after respondents disclosed.

Significant Difference in Mean Scores for “Treated Me Better Afterwards” for Faculty/Staff Reactions to Disclosures in HS vs. College

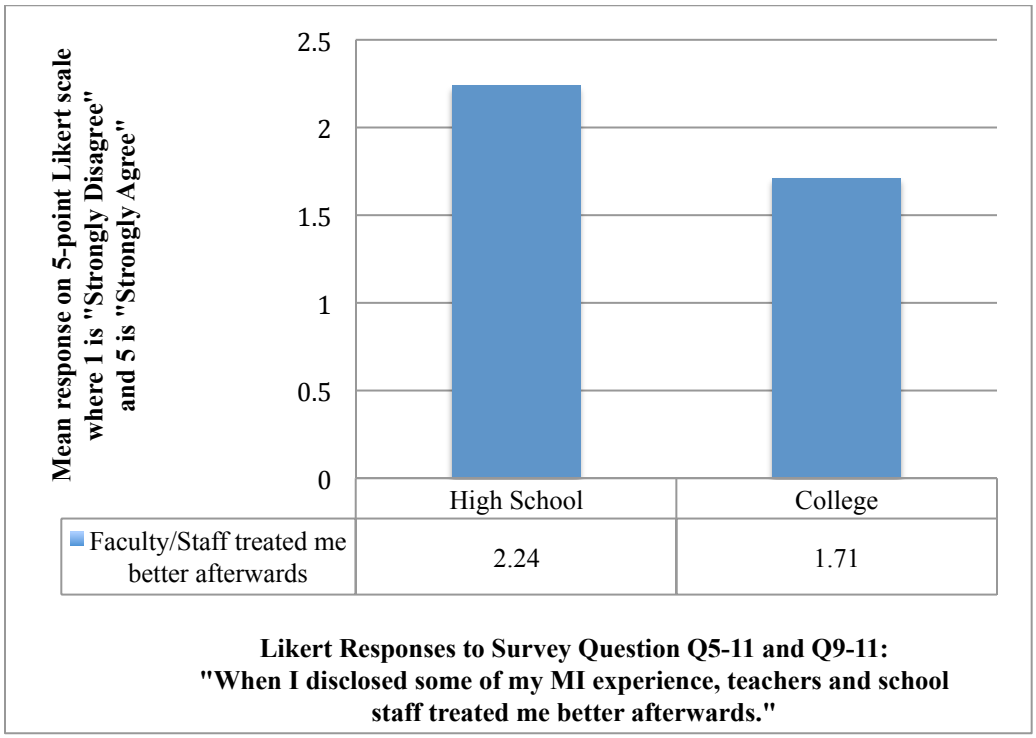



*Figure 6.4.10.* Mean difference values representing instances of survey respondents feeling “treated better” by school faculty or staff after making a mental health-related disclosure to them. When prompted with the statement “When I disclosed some of my MI (mental illness) experience, teachers and school staff treated me better afterwards,” respondents were asked to choose a response from among the following: “Strongly Disagree” [1], “Disagree” [2], “Not Sure” [3], “Agree’ [4], or “Strongly Agree” [5]. The mean responses, as shown in this graph, are 2.24 (between “Disagree” and “Not Sure” in high school) and 1.71 (between “Disagree” and “Strongly Disagree” in college.) This change in responses from high school to college is significant ($t_{20} = 2.45$, $p < .005$). See Table 6.8.15 for details on the paired samples t-test performed.

We can interpret these results as meaning that on average, survey respondents felt that more high school faculty and staff treated them "better" after receiving a mental health disclosure from the students than college faculty and staff did. However, this finding does not necessarily mean that college faculty and staff did not treat students as well as high school teachers or staff after receiving disclosures; instead, the finding could imply that college faculty and staff were *already* treating survey respondents fairly well, thus there was less room for improved interactions after respondents disclosed.

**Disclosures to Peers in High School.** While the section above related to disclosures to faculty and school staff, the section below focuses on survey respondents' mental health disclosures to peers. First, recipient types are presented (see Figure 6.5); next, mean differences for peer recipients in high school and college are displayed (see Table 6.9.1 through 6.9.4); respondents' reasons for making disclosures to peers in high school and college, as well as mean differences in these reasons at the two points in time, are then presented (see Tables 6.10.1 through 6.10.12 and Figure 6.6); and, finally, respondents' perceptions of the peer reactions to disclosures are presented (see Figures 6.7.1 and 6.7.2, and Tables 6.11.1, 6.11.2, and 6.11.3).

***Recipients.***

Frequencies for Peer Recipients of Disclosures: HS vs. College

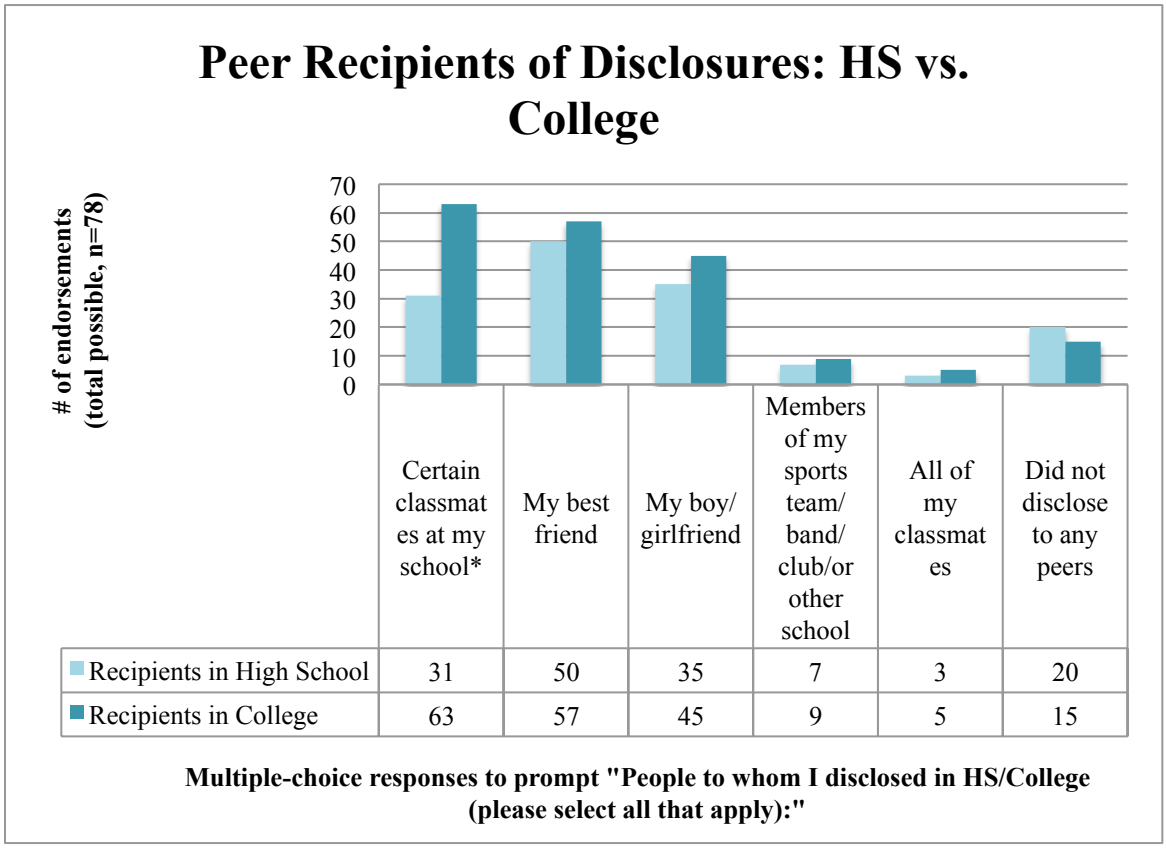



*Figure 6.5*. This table illustrates the number of survey respondents who endorsed mental health disclosures to various types of peers. If respondents answered "Yes" to the following survey prompts, they were then asked about the specific types of peers who received their disclosures:

> "I disclosed to certain classmates at my high school" (survey question Q5-13), and
> "I disclosed to certain classmates at my college" (survey question Q9-13).

Respondents who answered "No" to the above prompts are summed in the far right column ("Did not disclose to any peers"). A total of 20 respondents did not disclose to any peers in high school (26% of the total sample of 78), and 15 (19%) did not disclose to any peers in college.

*Note.* The asterisk (*) on the far left column ("Certain classmates at my school") brings attention to the finding that this difference in number of disclosures to "certain

classmates" in high school versus college is significant. These statistical findings are presented in Table 6.9.1.

The high school and college-related survey questions that are related to this figure are the following:

"My best friend" (Q5-46-2 and Q9-44-1)

"My boy/girlfriend" (Q5-46-3 and Q9-44-6)

"Members of my sports team, band, club, or other school grp" (Q5-46-15, Q9-44-13)

"All of my classmates at school" (Q5-46-9 and Q9-44-8)

Table 6.9.1
*Significant Difference in Mean Disclosures to "Certain Classmates": HS vs. College*
t-Test
Paired Samples Statistics

| | Mean | N | Std. Deviation | Std. Error Mean |
|---|---|---|---|---|
| I disclosed my MI to certain classmates at my HS. | 1.49 | 57 | .504 | .067 |
| I disclosed my MI to certain classmates at my college. | 1.12 | 57 | .331 | .044 |

Paired Samples Correlations

| | N | Correlation | Sig. |
|---|---|---|---|
| I disclosed my MI to certain classmates at my HS. & I have disclosed my MI to certain classmates at my college. | 57 | .167 | .215 |

Paired Samples Test

| | Paired Differences | | | | | t | df | Sig. (2-tailed) |
|---|---|---|---|---|---|---|---|---|
| | Mean | Std. Dev. | Std. Error Mean | 95% Confidence Interval of the Difference Lower | Upper | | | |
| I disclosed my MI to certain classmates at my HS. - I disclosed my MI to certain classmates at my college. | .368 | .555 | .074 | .221 | .516 | 5.010 | 56 | .000** |

*Note*. High School (HS) and College experiences of disclosing to "certain classmates at my school" are not significantly correlated ( r = .17, p is .215). There is a significant difference between HS and College mean scores for mental health disclosures to "certain classmates at my school" ($t_{56}$ = 5.0, p < .001). The average HS score for disclosing to certain classmates is .37 points lower (where 1 = "Yes" and 2 = "No") than the average College score (95% CI [.22, .52]). None of the other comparisons of type of peer recipients show significant differences in means between HS and College (see Tables 6.9.2, 6.9.3, and 6.9.4). The survey questions related to this table are Q5-13 for High School and Q9-13 for College.

** p < .001

Table 6.9.2

*No Significant Difference in Mean Disclosures to "My Best Friend": HS vs. College*

t-Test

Paired Samples Statistics

| | Mean | N | Std. Deviation | Std. Error Mean |
|---|---|---|---|---|
| People to whom I disclosed in HS: My best friend | .95 | 43 | .213 | .032 |
| People to whom I have disclosed while in COLL: My best friend | .93 | 43 | .258 | .039 |

Paired Samples Correlations

| | | N | Correlation | Sig. |
|---|---|---|---|---|
| | People to whom I disclosed in HS: My best friend & People to whom I have disclosed while in COLL: My best friend | 43 | -.060 | .700 |

Paired Samples Test

| | | Paired Differences | | | | | t | df | Sig. (2-tailed) |
|---|---|---|---|---|---|---|---|---|---|
| | | Mean | Std. Deviation | Std. Error Mean | 95% Confidence Interval of the Difference Lower | Upper | | | |
| Pair 1 | …in HS: My best friend - …in COLL: My best friend | .023 | .344 | .052 | -.083 | .129 | .443 | 42 | .660 |

*Note*. High School (HS) and College disclosures to "my best friend" are not significantly correlated ( r = -.06, p is .700). In addition, there is no significant difference between HS and College mean scores for disclosures to "my best friend" ( $t_{42}$ = .44, p is .660). The survey questions related to this table are Q5-46-2 for High School and Q9-44-1 for College.

Table 6.9.3

*No Significant Difference in Mean Disclosures to "My Boyfriend/Girlfriend": HS vs. College*

t-Test

Paired Samples Statistics

| | Mean | N | Std. Deviation | Std. Error Mean |
|---|---|---|---|---|
| People to whom I disclosed in HS: My boyfriend/girlfriend | .82 | 33 | .392 | .068 |
| People to whom I have disclosed while in college: My boy/girlfriend | .79 | 33 | .415 | .072 |

Paired Samples Correlations

| | N | Correlation | Sig. |
|---|---|---|---|
| People to whom I disclosed in HS: My boyfriend/girlfriend & People to whom I have disclosed while in college: My boy/girlfriend | 33 | .716 | .000** |

Paired Samples Test

| | Paired Differences | | | | | t | df | Sig. (2-tailed) |
|---|---|---|---|---|---|---|---|---|
| | Mean | Std. Deviation | Std. Error Mean | 95% Confidence Interval of the Difference Lower | Upper | | | |
| ….in HS: My boyfriend/girlfriend - …. in college: My boy/girlfriend | .030 | .305 | .053 | -.078 | .138 | .571 | 32 | .572 |

High School (HS) and College disclosures to "my boy/girlfriend" are significantly correlated ( r = .72, p is < .001). There is no significant difference between HS and College mean scores for disclosures to "my boy/girlfriend" ( $t_{32}$ = .57, p = .572). The survey questions related to this table are Q5-46-3 for High School and Q9-44-6 for College.

**p< .001

Table 6.9.4

*No Significant Difference in Mean Disclosures to "My Sports Team, Club, Band, or Other Campus-Based group": HS vs. College*

t-test

Paired Samples Statistics

| | Mean | N | Std. Deviation | Std. Error Mean |
|---|---|---|---|---|
| People to whom I disclosed in HS: Members of my sports team/band/club/or other school-based group | .18 | 17 | .393 | .095 |
| People to whom I disclosed while in college: Members of my sports team, club, or other campus-based group | .18 | 17 | .393 | .095 |

Paired Samples Correlations

| | N | Correlation | Sig. |
|---|---|---|---|
| … in HS: Members of my sports team/band/club/or other school grp & … in college: Members of my sports team, club, or other school grp | 17 | .190 | .464 |

Paired Samples Test

| | Paired Differences | | | | | t | df | Sig. (2-tailed) |
|---|---|---|---|---|---|---|---|---|
| | Mean | Std. Deviation | Std. Error Mean | 95% Confidence Interval of the Difference Lower | Upper | | | |
| … in HS: Members of my sports team/band/club/or other school group – … in college: Members of my sports team, club, or other campus group | .000 | .500 | .121 | -.257 | .257 | .000 | 16 | 1.000 |

High School (HS) and College disclosures to "my sports team, band, club, or other campus-based group" are not significantly correlated ( r = .19, p is .464). There is no significant difference between HS and College mean scores for disclosures to "members of my sports team, band, club, or other campus-based group" ( $t_{16}$ = .000, p is 1.000). The survey questions related to this table are Q5-46-15 for High School and Q9-44-13 for College.

Table 6.10.1
*High School Disclosures to Peers – Reasons for and Reactions to*

| | n | % who disclosed to peers in HS (n=57) | % who disclosed to anyone (n=58) | % total sample (n=78) |
|---|---|---|---|---|
| **Reasons to disclose to HS peers or classmates** | | | | |
| *(Responded "Strongly Agree" or "Agree" to the following items)*[1] | | | | |
| *Relational reasons (115)* | | | | |
| so people could support me if I needed help managing my illness | 31 | 54.4 | 53.4 | 39.7 |
| so my peers could understand me better | 27 | 47.4 | 46.4 | 34.6 |
| in order to deepen my relationship with my boy/girlfriend | 24 | 42.1 | 41.4 | 30.8 |
| in order to share details about my life and deepen friendships | 22 | 38.6 | 37.9 | 28.2 |
| to broaden my network of peers who also have mental illness | 11 | 19.3 | 19.0 | 14.1 |
| *Identity and Emotional reasons (51)* | | | | |
| because it was a relief to not keep it a secret | 31 | 54.4 | 53.4 | 39.7 |
| because I am comfortable with myself and it is part of me | 20 | 35.1 | 34.5 | 25.6 |
| *Advocacy reasons (41)* | | | | |
| to change people's negative attitudes about mental illness | 23 | 40.4 | 39.7 | 29.5 |
| in order to be a role model for other young people | 18 | 31.6 | 31.0 | 23.1 |
| *Academic reasons (5)* | | | | |
| so peers could help me with assignments if I had to miss school | 5 | 8.8 | 8.6 | 6.4 |
| *Other (24)* | | | | |
| Only when it was so obvious that I could no longer hide it (e.g. after a hospitalization and subsequent return to school) | 24 | 42.1 | 41.4 | 30.8 |
| **Reactions to student's disclosure(s) by HS peers or classmates** | | | | |
| ***"****When I disclosed some of my mental illness experience in high school..."*[2] | | | | |
| *Positive* | | | | |
| my classmates listened respectfully | 19 | 33.3 | 32.8 | 24.4 |
| my classmates accepted me | 18 | 31.6 | 31.0 | 23.1 |
| I gained friends | 11 | 19.3 | 19.0 | 14.1 |
| my classmates understood me | 10 | 17.5 | 17.2 | 12.8 |
| my classmates treated me better afterwards | 5 | 8.8 | 8.6 | 6.4 |
| *Negative* | | | | |
| I lost friends | 11 | 19.3 | 19.0 | 14.1 |
| my classmates seemed uncomfortable | 9 | 15.8 | 15.5 | 11.5 |
| my classmates treated me worse afterwards | 8 | 14.0 | 13.8 | 10.3 |
| *Neutral* | | | | |
| my classmates treated me the same afterwards | 22 | 38.6 | 37.9 | 28.2 |
| it didn't affect my friendships | 8 | 14.0 | 13.8 | 10.3 |

[1,2]*Note*: Survey participants responded on a 5-point Likert scale: "Strongly Agree" [5], "Agree" [2], "Not Sure" [3], "Disagree" [2], and "Strongly Disagree" [1].

Reasons *To* Disclose to Peers: HS vs. COLLEGE

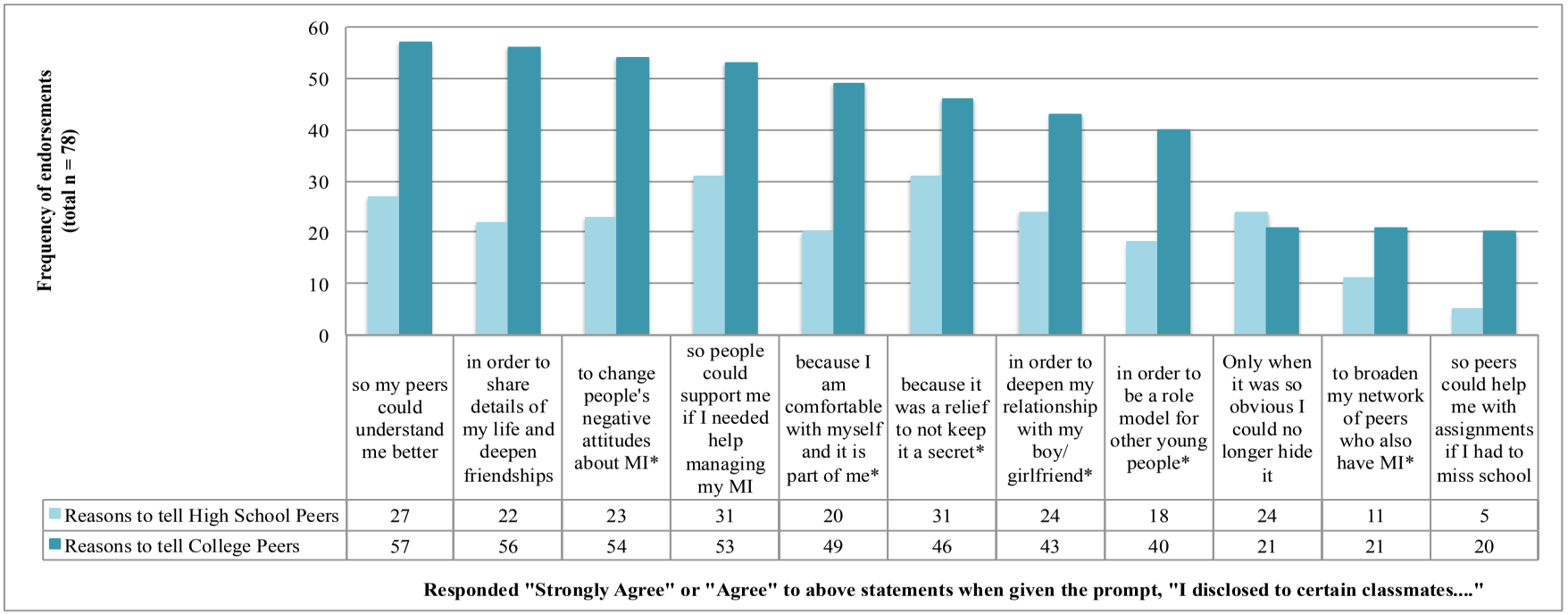



*Figure 6.6.1.* From left to right, the bars above represent responses to the following pairs of HS/COLL survey items related to reasons for disclosing to peers: Q5-17 and Q9-14 “understand me”; Q5-18 and Q9-16 “share details and deepen friendships”; Q5-26 and Q9-25 “change negative attitudes”; Q5-28 and Q9-27 “support me if I needed help”; Q5-23-0 and Q9-22 “comfortable with myself”; Q5-24 and Q9-23 “relief to not keep secret”; Q5-20 and Q9-17 “deepen relationship with boy/girlfriend”; Q5-27 and Q9-26 “be a role model”; Q5-25 and Q9-24 “only when could no longer hide”; Q5-29 and Q9-21 “broaden network of peers with MI”; and Q5-16 and Q9-15 “help me with assignments.” The six reasons given for disclosing to peers that have an asterisk (*) in their label, above, show mean scores from HS to College that are significantly different. Statistics on these mean differences are available in Tables 6.8.2 through 6.8.12.

***Reasons to disclose to peers.*** It is striking that the top two reasons given for disclosing to peers in college, "so my peers could understand me better" and "in order to share details of my life and deepen friendships," are both *relational*. These reasons highlight the attention that emerging adults give to interactions with same-age peers, and the importance of friendships. In contrast, the two most frequent reasons given for disclosing to peers in high school are: "so people could support me if I needed help managing my mental illness" and "because it was a relief to not keep it a secret." These two high school reasons imply (1) a desire for instrumental assistance and/or emotional supports, and (2) a personal coping mechanism or way to manage stress, respectively. These top high school reasons are not as explicitly relational or pro-social, as are the top two college reasons. That said, "so people could support me" may still be considered a relational reason (see Figure 6.6.2 for more on these categories), as the goal with this type of disclosure is interpersonal support.

In addition, the third most common reason for disclosing to peers in college, "to change people's negative attitudes about mental illness," as well as the eighth most common reason, "in order to be a role model for other young people considering disclosing their own mental illnesses" are both what we might call *advocacy* or *educational* reasons. A full 54 of the total sample of 78 respondents endorse disclosing to peers in college in order to change negative attitudes, using disclosure as a method to combat mental health stigma. Relatedly, 40 respondents endorsed the idea of modeling mental health disclosure as a means of encouraging peers to also consider disclosing.

It is noteworthy in Figure 6.6.1 that the only reason for disclosing to peers that was more frequent in high school than in college is "only when it was so obvious that I

could no longer hide it." This could mean that respondents become more likely to disclose intentionally and strategically in college, as opposed to as a reaction to crisis or to "being found out." It could also imply, however, that respondents' symptoms are better managed in college, thus that there is less of a chance that their mental health conditions would be "obvious" or visible to peers. However, given that the trend among nearly all of the items is that reasons to disclose become more frequent in college, it is likely that intentional and strategic telling (rather better managed symptoms) explains this finding.

And, finally, the graph shows that in both high school and college, the least likely reason for disclosing an aspect of one's mental illness to peers is the same: "so [they] could help me with assignments if I had to miss school." Given the relatively high and stable rate of hospitalizations for this sample during both secondary school and college (see Table s 6.5.3 and 6.7.2), it may seem surprising that more respondents did not endorse this statement. However, when considering adolescent and emerging adult development, the finding makes more sense. Here, again, survey respondents illustrate that their primary reasons for sharing private and personal information with friends and classmates are *relational* – to forge, deepen, or maintain close friendships - and are not academic.

Reasons to Disclose to Peers Organized into Categories

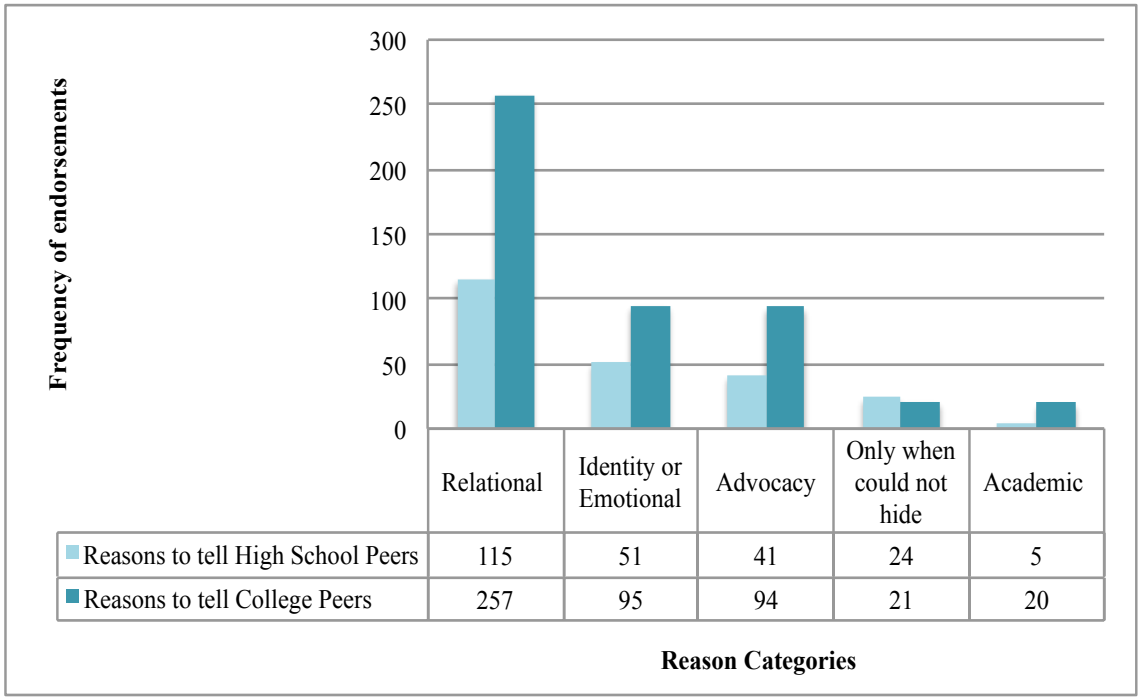



Figure 6.6.2. The five categories in this bar chart represent the types of reasons that respondents gave for disclosing to their peers in educational contexts (see Table 6.10.1). Responses of "Agree" or "Strongly Agree" for each of the statements, below, are totaled in each category. Responses are for the prompt, "I disclosed to certain peers and classmates…." And respondents had 11 responses from which to select and were asked to "please choose all that apply."

*Relational reasons to disclose*

so my peers could understand me better

in order to share details about my life and deepen friendships

so that people could support me if I needed help managing my illness

in order to deepen my relationship with my boy/girlfriend

to broaden my network of peers who also have mental illness

*Identity or Emotional reasons to disclose*

because I am comfortable with myself and it is part of me

because it was a relief to not keep it a secret

*Advocacy reasons to disclose*

To change peoples' negative attitudes about mental illness

In order to be a role model for other young people

*Academic reasons to disclose*

So peers could help me with assignments if I had to miss school

Only when it was so obvious that I could no longer hide it

It is noteworthy that "Relational" reasons for disclosing to peers are by far the majority in both high school and college. In fact, the total number of "Relational" reasons for disclosing in college (257) is higher than all of the reasons in the other four categories combined (230). In high school the relational reasons total to 115, while the other four categories total to 121, still putting relational reasons far ahead of each of the other four categories, and nearly equaling them in combination.

The next most common category of reason to disclose to peers is "Identity or Emotional." This category includes the following two reasons: "because it was a relief to not keep it a secret," and "because I am comfortable with myself and it is part of me." Although the former reason implies a coping strategy, the latter here suggests identity development, and a move from feeling less "comfortable" with oneself in high school, to a place of feeling that one's diagnosis is an important part of one's identity – and potentially worth sharing – while it is not the entirety of one's identity.

It is interesting to note that the "Advocacy" reasons in college are just as common as the "Identity or Emotional" reasons given, highlighting continued identity development in emerging adulthood, as well as movement toward seeking and finding a "purpose." Indeed, it could be argued that mental health education, awareness, and advocacy activities and related disclosures are part of a search for "purpose" among many of this study's participants. As the move through college and their own recoveries, they become more outspoken about their pasts and the challenges that they continue to face. Many of them become more outwardly political and openly active in on-campus mental health clubs and organizations such as Active Minds; and for some, "mental health advocate" becomes a key component of identity.

Disclosing "only when I could no longer hide it" was endorsed slightly more frequently in high school than in college. As noted above, this finding can be interpreted in multiple ways: (1) it is possible that symptoms are managed better in college and are less "visible" so students don't experience "no longer being able to hide it," or (2) students disclose in college before an event that would make their mental health status obvious (such as a hospitalization). Given the fact that the number of hospitalizations in middle school/high school and college is nearly the same (17 and 18, respectively), it seems logical that the latter reason here is more likely (see Tables 6.5.3 and 6.7.2). Respondents are disclosing to their peers not during or after a "crisis," but, instead, in an effort to forge, maintain, or deepen friendships.

And, finally, academic reasons for disclosing (such as needing help with coursework after an absence due to a hospitalization) are the least likely reasons to disclose to peers at both the high school and college level.

Table 6.10.2

*No Significant Difference in Mean Reasons to Disclose to Peers to "Understand Me Better": HS vs. COLLEGE*

*t*-test

Paired Samples Statistics

| | Mean | N | Std. Deviation | Std. Error Mean |
|---|---|---|---|---|
| I disclosed some of my MI experience in HS so my peers could understand me better. | 4.19 | 26 | .694 | .136 |
| I disclosed some of my MI experience in college so peers could understand me better. | 4.35 | 26 | .797 | .156 |

Paired Samples Correlations

| | N | Correlation | Sig. |
|---|---|---|---|
| I disclosed some of my MI experience in HS so my peers could understand me better. & I disclosed some of my MI experience in college so peers could understand me better. | 26 | .381 | .055 |

Paired Samples Test

| | Paired Differences | | | | | t | df | Sig. (2-tailed) |
|---|---|---|---|---|---|---|---|---|
| | Mean | Std. Deviation | Std. Error Mean | 95% Confidence Interval of the Difference Lower | Upper | | | |
| I disclosed some of my MI experience in HS so my peers could understand me better. - I disclosed some of my MI experience in college so peers could understand me better. | -.154 | .834 | .164 | -.491 | .183 | -.941 | 25 | .356 |

*Note.* High School (HS) and College experiences of disclosing to "certain friends and classmates" at school for the purpose of being better understood (survey questions Q5-17 and Q9-14, respectively) are not significantly correlated (r = .381, p = .055). There is no significant difference between HS and College mean scores for mental health disclosures to peers in order to be better understood ($t_{25}$ = .94, p = .356). The average HS score for telling peers about some aspect of one's mental illness is approximately .15 points below the average College score, on a 5-point scale where "Strongly Agree" with the statement is "5" (95% CI [-.49, .18]). However, this difference is not significant.

Table 6.10.3

*No Significant Mean Difference in Reasons to Disclose to Peers to "Deepen Friendships": HS vs. College*

*t*-test

Paired Samples Statistics

| | Mean | N | Std. Deviation | Std. Error Mean |
|---|---|---|---|---|
| I disclosed some of my MI experience in HS in order to share details about my life and deepen friendships. | 3.74 | 27 | 1.318 | .254 |
| I disclosed some of my MI experience in college in order to share details about my life and deepen friendships. | 4.07 | 27 | 1.174 | .226 |

Paired Samples Correlations

| | | N | Correlation | Sig. |
|---|---|---|---|---|
| Pair 1 | …. in HS in order to share details about my life and deepen friendships. & …. college in order to share details about my life and deepen friendships. | 27 | .510 | .007** |

Paired Samples Test

| | Paired Differences | | | | | t | df | Sig. (2-tailed) |
|---|---|---|---|---|---|---|---|---|
| | Mean | Std. Deviation | Std. Error Mean | 95% Confidence Interval of the Difference Lower | Upper | | | |
| …in HS in order to share details about my life and deepen friendships. - … in college in order to share details about my life and deepen friendships. | -.333 | 1.240 | .239 | -.824 | .157 | -1.396 | 26 | .174 |

*Note.* High School (HS) and College experiences of disclosing "some of my mental illness experience" at school for the purpose of sharing details about one's life and deepening friendships (survey questions Q5-18 for HS and Q9-16 for College) are strongly, positively, and significantly correlated ($r = .51$, $p = .007$). There is no significant difference between HS and College mean scores for mental health disclosures to peers in order to deepen friendships

($t_{26} = 1.4$, $p = .174$). The average HS score for telling peers about some aspect of one's mental illness in order to deepen friendships is .33 points lower than the average College score on this item (95% CI [-.82, .16]) , where responses are given on a 5-point scale and "Strongly Agree" is 5. This mean difference, however, is not significant.

**$p < .01$

Table 6.10.4

Significant Difference in Mean Reasons to Disclose to Peers to "Change People's Negative Attitudes": HS vs. College

t-test

Paired Samples Statistics

| | Mean | N | Std. Deviation | Std. Error Mean |
|---|---|---|---|---|
| When I was in HS, I disclosed some of my MI experience because I wanted to change people's negative attitudes about mental illness. | 2.82 | 57 | 1.377 | .182 |
| In college, I have disclosed some of my mental illness experience because I think sharing my story can change people's negative attitudes about mental illness. | 3.91 | 57 | 1.090 | .144 |

Paired Samples Correlations

| | N | Correlation | Sig. |
|---|---|---|---|
| When I was in HS, I disclosed some of my MI experience because I wanted to change people's negative attitudes about mental illness. & In college, I have disclosed some of my MI experience because I think sharing my story can change people's negative attitudes about mental illness. | 57 | .275 | .038* |

Paired Samples Test

| | Paired Differences | | | | | t | df | Sig. (2-tailed) |
|---|---|---|---|---|---|---|---|---|
| | | | | 95% Confidence Interval of the Difference | | | | |
| | Mean | Std. Deviation | Std. Error Mean | Lower | Upper | | | |
| When I was in HS…because I wanted to change people's negative attitudes about MI. - In college… because I think sharing my story can change people's negative attitudes about MI | -1.088 | 1.503 | .199 | -1.487 | -.689 | -5.463 | 56 | .000** |

Note. The mean score for disclosing "some of my mental illness experience" to peers in High School (HS) to "change people's negative attitudes about mental illness" is 2.82 on a 5-point scale where 1 is "Strongly Disagree" and 5 is "Strongly Agree." (The HS average score, then, is between "Not Sure" and "Disagree.") In College, the mean score on this item is 3.91 (almost at "Agree").

HS and College decisions to disclose because of wanting to "change people's negative attitudes about mental illness" (survey questions Q5-26 for HS and Q9-25 for College) are significantly correlated ($r = .275$, $p = .038$). In addition, there is a significant difference between HS and College mean scores ($t_{56} = 5.46$, $p = .000$), with the average College score for disclosing 1.1 points higher than the average HS score on this item (95% CI [-1.5, -.69]).

*p < .05, **p < .001

Table 6.10.5

*No Significant Mean Difference in Reasons to Disclose to Peers "So People Can Support Me if I Need Help Managing My Mental Illness": HS vs. College*

*t*-test

Paired Samples Statistics

| | Mean | N | Std. Deviation | Std. Error Mean |
|---|---|---|---|---|
| When I was in HS, I disclosed some of my MI experience so that people could support me if I needed help managing my MI. | 3.32 | 57 | 1.136 | .151 |
| In college, I have disclosed some of my mental illness experience so that people in my daily life could support me if I needed help managing my MI. | 2.16 | 57 | 13.675 | 1.811 |

Paired Samples Correlations

| | N | Correlation | Sig |
|---|---|---|---|
| … in HS, I disclosed…so people could support me if I needed help managing my MI. & In college, I disclose…so people can support me if I needed help managing my MI. | 57 | .282 | .034* |

Paired Samples Test

| | Paired Differences | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | | | | 95% Confidence Interval of the Difference | | | | |
| | Mean | Std. Deviation | Std. Error Mean | Lower | Upper | t | df | Sig. (2-tailed) |
| … in HS, I disclosed so people could support me if I needed help managing my MI. - In college, I disclosed so people can support me if I need help managing my MI. | 1.158 | 13.399 | 1.775 | -2.397 | 4.713 | .652 | 56 | .517 |

*Note.* Mean HS and College scores for disclosures to peers to elicit their support in managing one's MI are 3.32 and 2.16 respectively. Scores are on a 5-point scale of agreement where "Strongly Agree" is 5, "Agree" is 4, "Not Sure" is 3, "Disagree" is 2, and "Strongly Disagree" is 1. Mean scores show that, on average, students were "not sure" if their disclosures to peers in high school were made in an effort to secure support.

When in college, the students disagreed with the statement, meaning that they did not generally disclose to gain peer support in managing their illness.

High School (HS) and College decisions to disclose "some of my mental illness experience" so that other people could offer support to the respondent if he or she "needed help" managing his or her mental illness (survey questions Q5-28 and Q9-27, respectively) are weakly, positively, and significantly correlated ($r = .282$, $p = .034$). There is no significant difference between HS and College mean scores for mental health disclosures to peers in order to encourage peers to be supportive if respondents need help ($t_{56} = .652$, $p = .517$). The average High School score for disclosing some aspect of one's mental illness in order to gain peer support if needed is 1.16 points higher than the average College score on this item (95% CI [ -2.40, 4.71]), but this difference is not significant.

Table 6.10.6

*Significant Difference in Mean Reasons to Disclose to Peers – "I Am Comfortable with Myself and it is Part of Me": HS vs. College*

*t*-test

Paired Samples Statistics

| | Mean | N | Std. Deviation | Std. Error Mean |
|---|---|---|---|---|
| When I was in HS, I disclosed some of my MI experience because I am comfortable with myself and it is part of me. | 2.53 | 57 | 1.351 | .179 |
| In college, I have disclosed some of my MI experience because I am comfortable with myself and it is part of me. | 3.74 | 57 | 1.094 | .145 |

Paired Samples Correlations

| | N | Correlation | Sig. |
|---|---|---|---|
| When I was in HS, I disclosed some of my MI experience because I am comfortable with myself and it is part of me. & In college, I have disclosed some of my MI experience because I am comfortable with myself and it is part of me. | 57 | .180 | .180 |

Paired Samples Test

| | Paired Differences | | | | | t | df | Sig. (2-tailed) |
|---|---|---|---|---|---|---|---|---|
| | Mean | Std. Deviation | Std. Error Mean | 95% Confidence Interval of the Difference Lower | Upper | | | |
| When I was HS, I disclosed some of my MI experience because I am comfortable and it is part of me. - In college, I disclosed some of my MI experience because I am comfortable and it is part of me. | -1.211 | 1.578 | .209 | -1.629 | -.792 | -5.791 | 56 | .000** |

*Note.* Mean HS and College scores for disclosures to peers due to "comfort" with oneself and feeling that "it is part of me" (survey questions Q5-23-0 and Q9-22, respectively) are 2.53 and 3.74. Scores are on a 5-point scale of agreement where "Strongly Agree" is 5, "Agree" is 4, "Not Sure" is 3, "Disagree" is 2, and "Strongly Disagree" is 1. Mean scores show that, on average, students fell between "Disagree" and "Not sure" while in high school, but they shifted to between "Not Sure" and "Agree" on this item once in college.

These mean scores are not significantly correlated (r = .18, p = .18), and there is a significant difference between them ($t_{56}$ = 5.7, p =.000). The average College score for disclosing some aspect of one's mental illness because of feeling comfortable and "it is part of me" is 1.2 points higher than the average HS score on this item (95% CI [ -1.63, -.79]), where responses are given on a 5-point scale and "Strongly Agree" is 5.

**p < .001

Table 6.10.7

*Significant Difference in Mean Reasons to Disclose to Peers because "It was a Relief to Not Keep it a Secret": HS vs. College*

*t*-test

Paired Samples Statistics

| | Mean | N | Std. Deviation | Std. Error Mean |
|---|---|---|---|---|
| When I was in HS, I disclosed some of my MI experience because it was a relief to not keep it a secret. | 3.05 | 57 | 1.315 | .174 |
| In college, I have disclosed some of my MI experience because it is a relief to not keep it a secret. | 3.67 | 57 | 1.058 | .140 |

Paired Samples Correlations

| | N | Correlation | Sig. |
|---|---|---|---|
| When I was in HS, I disclosed some of my MI experience because it was a relief to not keep it a secret. & In college, I have disclosed some of my MI experience because it is a relief to not keep it a secret. | 57 | .295 | .026* |

Paired Samples Test

| | Paired Differences | | | | | t | df | Sig. (2-tailed) |
|---|---|---|---|---|---|---|---|---|
| | Mean | Std. Deviation | Std. Error Mean | 95% Confidence Interval of the Difference Lower | Upper | | | |
| When I was in HS, I disclosed some of my MI experience because it was a relief to not keep it a secret. - In college, I have disclosed some of my MI experience because it is a relief to not keep it a secret. | -.614 | 1.424 | .189 | -.992 | -.236 | -3.256 | 56 | .002** |

*Note.* Mean HS and College decisions to disclose "some of my mental illness experience" to peers because "it was a relief to not keep it a secret" (survey questions Q5-24 and Q9-23, respectively) are 3.05 and 3.67 on a 5-point scale. Here, "Strongly Agree" is 5, "Agree" is 4, "Not Sure" is 3, "Disagree" is 2, and "Strongly Disagree" is 1. Mean scores show that, on average, students were unsure about disclosing because it was a "relief" in high school, while they fell between "Not Sure" and "Agree" once in college.

High School (HS) and College mean scores are significantly correlated (r = .295, p =.026). In addition, there is a significant difference between HS and College mean scores for mental health disclosures because of wanting to no longer keep it a secret ($t_{56}$ = 3.26, p = .002). The average College score for disclosing some aspect of one's mental illness because of not wanting to keep a secret is .61 points higher than the average HS score on this item (95% CI [ -.99, -. 24]), where responses are given on a 5-point scale and "Strongly Agree" is 5, while "Strongly Disagree" is 1.

*p < .05, **p < .01

Table 6.10.8

*Significant Difference in Mean Reasons to Disclose to Peers to "Deepen Relationship with Boy/Girlfriend": HS vs. College*

*t*-test

Paired Samples Statistics

| | Mean | N | Std. Deviation | Std. Error Mean |
|---|---|---|---|---|
| I disclosed some of my MI experience to my HS boy/girlfriend in order to deepen our relationship. | 3.68 | 28 | .905 | .171 |
| I disclosed some of my MI experience to my college boy/girlfriend in order to deepen our relationship. | 4.07 | 28 | 1.052 | .199 |

Paired Samples Correlations

| | N | Correlation | Sig. |
|---|---|---|---|
| I disclosed…to my HS boy/girlfriend in order to deepen our relationship. & I disclosed…to my college boy/girlfriend in order to deepen our relationship. | 28 | .609 | .001** |

Paired Samples Test

| | Paired Differences | | | | | t | df | Sig. (2-tailed) |
|---|---|---|---|---|---|---|---|---|
| | Mean | Std. Deviation | Std. Error Mean | 95% Confidence Interval of the Difference Lower | Upper | | | |
| I disclosed…to my HS boy/girlfriend in order to deepen our relationship. - I disclosed…to my college boy/girlfriend in order to deepen our relationship. | -.393 | .875 | .165 | -.732 | -.054 | -2.375 | 27 | .025* |

*Note.* Mean HS and College decisions to disclose "some of my mental illness experience" to peers in order to "deepen a relationship" with a boy- or girlfriend (survey questions Q5-20 and Q9-17, respectively) are 3.68 and 4.07 on a 5-point scale. Here, "Strongly

Agree" is 5, "Agree" is 4, "Not Sure" is 3, "Disagree" is 2, and "Strongly Disagree" is 1. Mean scores show that, on average, students fell between "Not Sure" and "Agree" in high school, while their average response in college was "Agree."

High School (HS) and College experiences of disclosing "some of my mental illness experience" at school for the purpose of deepening one's romantic relationship with a boy- or girlfriend (survey questions Q5-20 and Q9-17, respectively) are strongly positively, and significantly correlated ($r = .61$, $p = .001$). In addition, there is a significant difference between HS and College mean scores for mental health disclosures to boy/girlfriends in order to deepen relationships ($t_{27} = 2.38$, $p = .025$). The average College score for telling one's boy- or girlfriend about some aspect of one's mental illness in order to deepen the relationship is .39 points higher than the average HS score on this item (95% CI [-.73, -.05]), where responses are given on a 5-point scale and "Strongly Agree" is 5.

*p < .05, **p < .01

Table 6.10.9

*Significant Difference in Mean Reasons to Disclose to Peers to "Be A Role Model": HS vs. College*

*t*-test

Paired Samples Statistics

| | Mean | N | Std. Deviation | Std. Error Mean |
|---|---|---|---|---|
| When I was in high school, I disclosed some of my MI experience in order to be a role model for other young people | 2.58 | 57 | 1.375 | .182 |
| In college, I have disclosed some of my MI experience in order to be a role model for other young people. | 3.60 | 57 | 1.223 | .162 |

Paired Samples Correlations

| | N | Correlation | Sig. |
|---|---|---|---|
| When I was in high school, I disclosed some of my MI experience in order to be a role model for other young people. & In college, I have disclosed some of my MI experience in order to be a role model for other young people. | 57 | .322 | .015* |

Paired Samples Test

| | Paired Differences | | | | | t | df | Sig. (2-tailed) |
|---|---|---|---|---|---|---|---|---|
| | Mean | Std. Deviation | Std. Error Mean | 95% Confidence Interval of the Difference Lower | Upper | | | |
| When I was in HS, I disclosed some of my MI experience in order to be a role model for other young people. - In college, I have disclosed some of my MI experience in order to be a role model for other young people. | -1.018 | 1.518 | .201 | -1.420 | -.615 | -5.062 | 56 | .000** |

*Note.* Mean HS and College decisions to disclose "some of my mental illness experience" to peers in order to "be a role model" (survey questions Q5-27 and Q9-26, respectively) are 2.58 and 3.50 on a 5-point scale. Here, "Strongly Agree" is 5, "Agree" is 4, "Not Sure" is 3, "Disagree" is 2, and "Strongly Disagree" is 1. Mean scores show that, on average, students fell between "Disagree" and "Not Sure" in high school, while their average response in college fell between "Not Sure" and "Agree."

High School (HS) and College mean decisions to disclose are significantly correlated ($r = .322$, $p = .015$). In addition, there is a significant difference between HS and College mean scores for mental health disclosures to peers because of wanting to be a role model ($t_{56} = 5.06$, $p = .000$). The average College score for disclosing some aspect of one's mental illness in order to be a role model for other young people is 1.02 points higher than the average HS score on this item (95% CI [ -1.42, -.62]), where responses are given on a 5-point scale and "Strongly Agree" is 5.

*$p < .05$, ** $p < .001$

Table 6.10.10

*No Significant Difference in Mean Reasons to Disclose to Peers "Only When I Could No Longer Hide It": HS vs. College*

*t*-test

Paired Samples Statistics

| | Mean | N | Std. Deviation | Std. Error Mean |
|---|---|---|---|---|
| When I was in HS, I disclosed some of my MI experience only when it was so obvious that I could no longer hide it. | 2.89 | 57 | 1.319 | .175 |
| In college, I have disclosed some of my MI experience only when it was so obvious that I could no longer hide it. | 2.74 | 57 | 1.247 | .165 |

Paired Samples Correlations

| | N | Correlation | Sig. |
|---|---|---|---|
| When I was in HS, I disclosed some of my MI experience only when it was so obvious that I could no longer hide it. & In college, I have disclosed some of my MI experience only when it was so obvious that I could no longer hide it. | 57 | .059 | .664 |

Paired Samples Test

| | Paired Differences | | | | | t | df | Sig. (2-tailed) |
|---|---|---|---|---|---|---|---|---|
| | Mean | Std. Deviation | Std. Error Mean | 95% Confidence Interval of the Difference Lower | Upper | | | |
| When I was in HS, I disclosed some of my MI experience only when it was so obvious that I could no longer hide it. - In college, I have disclosed some of my MI experience only when it was so obvious that I could no longer hide it. | .158 | 1.761 | .233 | -.309 | .625 | .677 | 56 | .501 |

*Note.* Mean HS and College decisions to disclose "some of my mental illness experience" only when it "could no longer be kept hidden" (survey questions Q5-25 and Q9-24, respectively) are 2.89 and 2.75 respectively. Scores are on a 5-point scale of agreement with the following survey statement, "When I was in HS/College, I disclosed some of my mental illness experience only when it was so obvious that I could no longer hide it." The response options are "Strongly Agree" [5], "Agree" [4], "Not Sure" [3], "Disagree" [2],

and “Strongly Disagree” is [1]. Mean scores show that, on average, students fell somewhere between “Not Sure” and “Disagree” at both points in time.

The mean scores for this particular type of disclosure in High School (HS) and College are not significantly correlated ($r = .059$, $p = .664$). In addition, there is no significant difference between HS and College mean scores on this item ($t_{56} = .677$, $p = .501$). The average High School score on this item is .16 points higher than the average College score on this item (95% CI [ -.31, .63]), but, again, this difference is not significant.

Table 6.10.11

*Significant Difference in Mean Reasons to Disclose to Peers "to Broaden Online Networks of Peers with Mental Illness": HS vs. College*

*t*-test

Paired Samples Statistics

| | Mean | N | Std. Deviation | Std. Error Mean |
|---|---|---|---|---|
| When I was in HS, I disclosed my MI online in order to broaden my network of peers who also have MI. | 2.58 | 24 | 1.442 | .294 |
| I have written about my MI online in college in order to broaden my network of peers who also have MI. | 3.67 | 24 | .963 | .197 |

Paired Samples Correlations

| | N | Correlation | Sig. |
|---|---|---|---|
| When I was in high school, I disclosed my mental illness online in order to broaden my network of peers who also have MI. & I have written about my MI online in college in order to broaden my network of peers who also have MI. | 24 | .271 | .200 |

Paired Samples Test

| | Paired Differences | | | | | t | df | Sig. (2-tailed) |
|---|---|---|---|---|---|---|---|---|
| | Mean | Std. Deviation | Std. Error Mean | 95% Confidence Interval of the Difference Lower | Upper | | | |
| When I was in HS, I disclosed my MI online in order to broaden my network of peers who also have MI. - I have written about my MI online in college in order to broaden my network of peers who also have MI. | -1.083 | 1.501 | .306 | -1.717 | -.449 | -3.535 | 23 | .002** |

*Note.* Mean HS and College scores for disclosures to peers online in order to broaden one's network of peers who also have MI (survey questions Q5-29 and Q9-21, respectively) are 2.58 and 3.67. Scores are on a 5-point scale of agreement with the survey statement, above, where "Strongly Agree" is 5, "Agree" is 4, "Not Sure" is 3, "Disagree" is 2, and "Strongly Disagree" is 1. Mean scores show that, on average,

students selected “Disagree” or “Not Sure” as a response to the prompt regarding their HS experiences, but they fall between “Not sure” and “Agree” in their College scores.

High School (HS) and College decisions to disclose online in an effort to broaden one’s network of peers who are also managing mental illness are not significantly correlated ($r = .271$, $p = .20$). In addition, there is a significant difference between HS and College mean scores for this particular reason to disclose ($t_{23} = 3.54$, p is = .002); the average High School score is 1.1 points lower than the average College score on this item (95% CI [ -1.72, -.45]), meaning that college students are more likely to seek out peers with mental illness online in an effort to either build community, access information, and/or seek social support from peers than are high school students.

**p < .01

Table 6.10.12

*No Significant Difference in Mean Reason to Disclose to Peers to "Help Me With Assignments if I Miss School Because of My Illness": HS vs. College*

*t*-test

Paired Samples Statistics

| | Mean | N | Std. Deviation | Std. Error Mean |
|---|---|---|---|---|
| I disclosed some of my MI experience at my HS so peers could help me schoolwork if I needed support or had to miss school because of my illness | 2.00 | 27 | 1.109 | .214 |
| I disclosed some of my MI experience to certain friends and classmates at my college so peers could help me with schoolwork if I needed support or had to miss school because of my illness | 2.44 | 27 | 1.340 | .258 |

Paired Samples Correlations

| | N | Correlation | Sig. |
|---|---|---|---|
| I disclosed…in HS so peers could help me with schoolwork if I needed support or had to miss school because of my illness. & I disclosed…in college so peers could help me with schoolwork if I needed support or had to miss school because of my illness. | 27 | .362 | .063 |

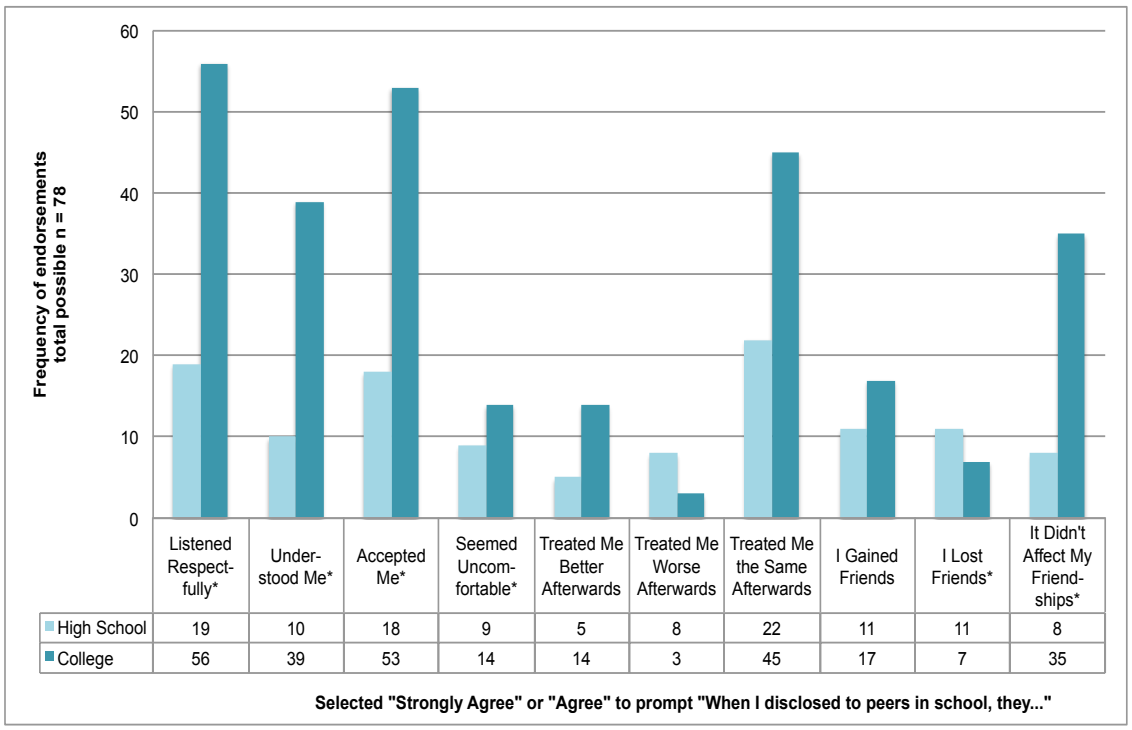
Paired Samples Test

| | Paired Differences | | | | | t | df | Sig. (2-tailed) |
|---|---|---|---|---|---|---|---|---|
| | Mean | Std. Deviation | Std. Error Mean | 95% Confidence Interval of the Difference Lower | Upper | | | |
| I disclosed…in HS so peers could help me with schoolwork if I needed support or had to miss school. - I disclosed…in college so peers could help me with schoolwork if I needed support or had to miss school. | -.444 | 1.396 | .269 | -.997 | .108 | -1.654 | 26 | .110 |

*Note*. High School (HS) and College experiences of disclosing to "certain friends and classmates" for the purpose of securing "help with schoolwork" (survey questions Q5-16 and Q9-15, respectively) are not significantly correlated (r = .36, p = .063). There is no

significant difference between HS and College mean scores for mental health disclosures to peers to secure academic support or help with coursework ($t_{26} = 1.65$, $p = .110$). The average score for disclosing to HS peers to secure help with schoolwork is .44 points lower than it is for disclosing to College peers for the same reason (95% CI [ -.10, .11]). However, this difference is not significant.

***Reactions from peers to disclosures.*** The next section of this chapter presents results related to survey respondents' perceptions of how their peers reacted to them when they (the respondents) made mental health disclosures. Figure 6.7.1 present various types of reactions and their frequencies; Tables 6.11.1, 6.11.2, and 6.11.3 display mean differences in peer reactions between high school and college, correlations between the two, and also mean differences; and Figure 6.7.2 shows both peer and faculty reactions to disclosures, comparing high school to college.




Peer Reactions to Disclosures: High School vs. College

*Figure 6.7.1.* Bar heights represent frequency of types of peer reactions to survey respondents' disclosures in high school versus college. From left to right, the bars above represent responses of "Strongly Agree" or "Agree" to the prompt, "When I disclosed to peers in school, they…" for the following high school and college-related survey items: Q5-30 and Q9-28 "listened respectfully"; Q5-31 and Q9-29 "understood me"; Q5-32 and Q9-30 "accepted me"; Q5-33 and Q9-31 "seemed uncomfortable"; Q5-34 and Q9-31.0 "treated me better afterwards"; Q5-35 and Q9-32 "treated me worse afterwards"; Q5-36 and Q9-33 "treated me the same afterwards"; Q5-38 and Q9-35 "I gained friends"; Q5-37 and Q9-34 "I lost friends"; and Q5-39 and Q9-36 "It didn't affect my friendships."

Note that reactions that have an asterisk (*) at the end of their labels, above, show mean change over time that is significant (see details in Table 6.11.3). The reactions that

change significantly between high school and college are: “Listened Respectfully”; “Understood me”; “Accepted Me”; “I lost friends”; and “It didn’t affect my friendships.” All of these changes are in a direction that is beneficial for the respondents, meaning more positive reactions to their disclosures in college and less likelihood of a disclosure affecting a friendship adversely.

In general, students seem to have had more positive reactions to their disclosures in college. The only exception to this is for the reactions “Seemed Uncomfortable,” which is more frequent in college than it was in high school. This finding may be related to the fact that the majority of disclosures to peers in high school were to “best friends,” while the majority of disclosures to peers in college were to “certain classmates at my school.” Best friends may be less likely to express discomfort at a friend’s disclosure, given the length and intimacy of the relationship, than “certain classmates” who may or may not know the college discloser as well.

Table 6.11.1
*Mean Peer Reactions to Disclosures: HS vs. College*

Responses to "When I disclosed some of my mental illness experience at my HS/College…"

Paired Samples Statistics

| | | Mean | N | Std. Deviation | Std. Error Mean |
|---|---|---|---|---|---|
| Pair 1 | HS classmates listened respectfully. | 3.41 | 27 | 1.010 | .194 |
| | College classmates listened respectfully. | 4.26 | 27 | .712 | .137 |
| Pair 2 | HS classmates understood me. | 2.85 | 27 | .989 | .190 |
| | College classmates understood me. | 3.78 | 27 | 1.013 | .195 |
| Pair 3 | HS classmates accepted me. | 3.41 | 27 | 1.047 | .202 |
| | College classmates accepted me. | 4.07 | 27 | .874 | .168 |
| Pair 4 | HS classmates seemed uncomfortable. | 3.11 | 27 | .892 | .172 |
| | College classmates seemed uncomfortable. | 2.52 | 27 | .893 | .172 |
| Pair 5 | HS classmates treated me better afterwards. | 2.44 | 27 | 1.188 | .229 |
| | College classmates treated me better afterwards. | 2.15 | 27 | .949 | .183 |
| Pair 6 | HS classmates treated me worse afterwards. | 2.67 | 27 | .832 | .160 |
| | College classmates treated me worse afterwards. | 2.89 | 27 | .641 | .123 |
| Pair 7 | HS classmates treated me the same afterwards. | 3.74 | 27 | .813 | .156 |
| | College classmates treated me the same afterwards. | 3.70 | 27 | .823 | .158 |
| Pair 8 | I gained friends in HS. | 2.79 | 28 | 1.067 | .202 |
| | I gained friends in college. | 2.89 | 28 | 1.100 | .208 |
| Pair 9 | I lost friends in HS. | 2.89 | 27 | 1.219 | .235 |
| | I lost friends in college. | 2.22 | 27 | 1.050 | .202 |
| Pair 10 | It didn't affect my HS friendships. | 2.50 | 28 | 1.000 | .189 |
| | It didn't affect my college friendships. | 3.32 | 28 | 1.124 | .212 |

*Note.* Responses to the prompt, above, were given on a 5-point Likert scale: "Strongly Agree" [5], "Agree" [4], "Not Sure" [3], "Disagree" [2], and "Strongly Disagree." Means here have been computed only for the survey respondents who did, in fact, make at least one disclosure to a peer in either high school of college. The total number of respondents who disclosed to at least one peer in high school is 50, or 64.1% of the sample, and the total number of respondents who disclosed to at least one peer in college is 63, or 80.8% of the sample (see Figure 6.5.1).

Table 6.11.2

*Correlations in Peer Reactions to Disclosures: HS vs. College*

Responses to "When I disclosed some of my mental illness experience at my HS/College…"

Paired Samples Correlations

| | | N | Correlation | Sig. |
|---|---|---|---|---|
| Pair 1 | "listened respectfully" | 27 | .168 | .401 |
| Pair 2 | "understood me" | 27 | .158 | .431 |
| Pair 3 | "accepted me" | 27 | .302 | .126 |
| Pair 4 | "seemed uncomfortable" | 27 | .311 | .114 |
| Pair 5 | "treated me better afterwards" | 27 | .008 | .970 |
| Pair 6 | "treated me worse afterwards" | 27 | .289 | .144 |
| Pair 7 | "treated me the same afterwards" | 27 | .398 | .040* |
| Pair 8 | "I gained friends." | 28 | .737 | .000** |
| Pair 9 | "I lost friends." | 27 | .441 | .021* |
| Pair 10 | "didn't affect my friendships." | 28 | .016 | .934 |

*p < .05, **p < .001

There are significant positive correlations between the following High School and College peer reactions to mental health disclosures: (1) "treated me better afterwards," (2) "I gained friend," and (3) "I lost friends."

Table 6.11.3

*Differences in Peer Reactions to Disclosures: HS vs. College*

Responses to "When I disclosed some of my mental illness experience at my HS/College…"

Paired Samples Test

| | Paired Differences | | | | | t | df | Sig. (2-tailed) |
|---|---|---|---|---|---|---|---|---|
| | | | | 95% CI of the Difference | | | | |
| | Mean | Std. Dev | Std. Error Mean | Lower | Upper | | | |
| Pair 1 "listened respectfully" | -.852 | 1.134 | .218 | -1.300 | -.403 | -3.905 | 26 | .001** |
| Pair 2 "understood me" | -.926 | 1.299 | .250 | -1.440 | -.412 | -3.705 | 26 | 001** |
| Pair 3 "accepted me" | -.667 | 1.144 | .220 | -1.119 | -.214 | -3.029 | 26 | .005** |
| Pair 4 "seemed uncomfortable" | .593 | 1.047 | .202 | .178 | 1.007 | 2.940 | 26 | .007** |
| Pair 5 "treated me better afterwards" | .296 | 1.514 | .291 | -.303 | .895 | 1.017 | 26 | .319 |
| Pair 6 "treated me worse afterwards" | -.222 | .892 | .172 | -.575 | .130 | -1.295 | 26 | .207 |
| Pair 7 "treated me same afterwards" | .037 | .898 | .173 | -.318 | .392 | .214 | 26 | .832 |
| Pair 8 "I gained friends." | -.107 | .786 | .149 | -.412 | .198 | -.721 | 27 | .477 |
| Pair 9 "I lost friends." | .667 | 1.209 | .233 | .188 | 1.145 | 2.865 | 26 | .008** |
| Pair 10"didn't affect my friendships." | -.821 | 1.492 | .282 | -1.400 | -.243 | -2.913 | 27 | .007** |

*Note.* Responses were given on a 5-point Likert scale: "Strongly Agree" [5], "Agree" [4], "Not Sure" [3], "Disagree" [2], and "Strongly Disagree." Correlations and means here have been computed for the survey respondents who did, in fact, make at least one disclosure to a peer in either high school or college. The total number of respondents who disclosed to at least one peer in high school is 50, or 64.1% of the sample, and the total number of respondents who disclosed to at least one peer in college is 63, or 80.8% of the sample (see Figure 6.5.1).

There are significant mean differences in the following perceived reactions from peers to mental health disclosures in high school and college (also see Figure 6.7.2):

"listened respectfully," p = .001 (95% CI [ -1.30, -.40)

"understood me," p = .001 (95% CI [-1.44, -.41])

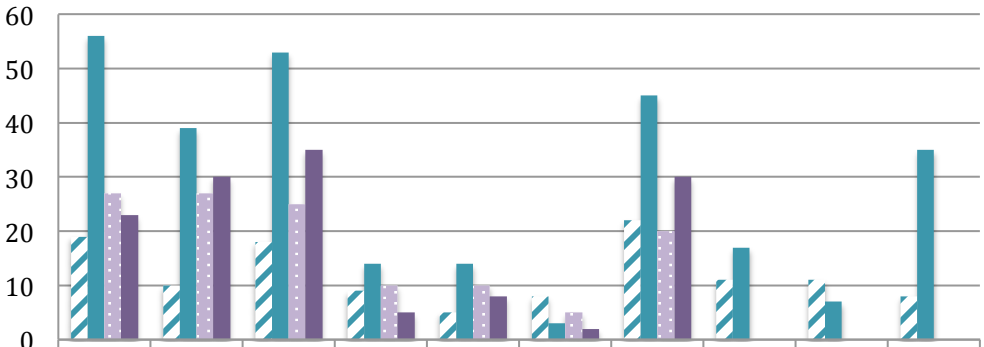
"accepted me," p = .005 (95% CI [-1.12, -.214])

"seemed uncomfortable," p = .007 (95% CI [.178, 1.007])

"I lost friends," p = .008 (95% CI [.188, 1.145])

"It didn't affect my friendships," p = .007 (95% CI [-1.40, -.243])

***$p < .001$, **$p < .01$, *$p < .05$.




| Frequency of endorsements | Listened Respectfully *^ | Understood Me* | Accepted Me*^ | Seemed Uncomfortable*^ | Treated Me Better Afterwards^ | Treated Me Worse Afterwards*^ | Treated Me the Same Afterwards | I Gained Friends | I Lost Friends* | It Didn't Affect My Friendships * |
|---|---|---|---|---|---|---|---|---|---|---|
| Peers in High School | 19 | 10 | 18 | 9 | 5 | 8 | 22 | 11 | 11 | 8 |
| Peers in College | 56 | 39 | 53 | 14 | 14 | 3 | 45 | 17 | 7 | 35 |
| Staff in High School | 27 | 27 | 25 | 10 | 10 | 5 | 20 | | | |
| Staff in College | 23 | 30 | 35 | 5 | 8 | 2 | 30 | | | |

**Selected "Strongly Agree" or "Agree" to above responses when given the prompts "When I disclosed to peers (they)..." and "When I disclosed to faculty (they)..."**

Peer and Faculty/Staff Reactions to Disclosures: High School vs. College

*Figure 6.7.2.* This bar chart combines results from Figures 6.4.7 and 6.7.1, displaying the frequency of endorsements for type of reaction to survey respondents' mental health disclosures. The reactions with an asterisk (*) next to their label show a significant difference between *peer* reactions in high school versus college (see Figure 6.7.1 and table 6.11.1, 6.11.2, and 6.11.3). The reactions with a caret symbol (^) next to their label show a significant difference between *faculty/staff* reactions in high school versus college (also see Figure 6.4.7 and Table 6.8.6). Reactions that are labeled with *both* symbols show significant change from high school to college for peers *and* faculty/staff.

**Disclosures to Peers and Related Associations**

The next section of this chapter display results related to whether disclosure to peers is predictive of other types of disclosures. Table 6.12.1 shows that mental health disclosures to college peers are, in fact, significantly correlated with mental health disclosures to college faculty. Table 6.12.3 shows that disclosures to college peers are note associated with use of Student Disability Services, while Table 6.12.4 shows that they are significantly associated with using campus Counseling and Psychological Services.

Table 6.12.1

*Disclosure to peers in High School does not predict disclosure to peers in college*

Regression

Descriptive Statistics

| | Mean | Std. Deviation | N |
|---|---|---|---|
| I have disclosed some of my MI experience to certain friends and classmates at my college. | 1.12 | .331 | 57 |
| I disclosed my MI to classmates at my HS. | 1.49 | .504 | 57 |

Correlations

| | | I have disclosed some of my MI experience to certain friends and classmates at my college. | I disclosed my MI to classmates at my HS. |
|---|---|---|---|
| Pearson Correlation | I have disclosed some of my MI experience to certain friends and classmates at my college | 1.000 | .167 |
| | I disclosed my MI to classmates at my HS. | .167 | 1.000 |
| Sig. (1-tailed) | I have disclosed some of my MI experience to certain classmates at my college. | . | .107 |
| | I disclosed my MI to classmates at my HS. | .107 | . |
| N | I have disclosed some of my MI experience to certain classmates at my college | 57 | 57 |
| | I disclosed my MI to classmates at my HS. | 57 | 57 |

Variables Entered/Removed[a]

| Model | Variables Entered | Variables Removed | Method |
|---|---|---|---|
| 1 | I disclosed my mental illness to classmates at my high school.[b] | . | Enter |

a. Dependent Variable: I have disclosed some of my mental illness experience to certain friends and classmates at my col...

b. All requested variables entered.

Model Summary

| Model | R | R Square | Adjusted R Square | Std. Error of the Estimate | Change Statistics | | | |
|---|---|---|---|---|---|---|---|---|
| | | | | | R Square Change | F Change | df1 | df2 | Sig. F Change |
| 1 | .167[a] | .028 | .010 | .329 | .028 | 1.577 | 1 | 55 | .215 |

a. Predictors: (Constant), I disclosed my mental illness to classmates at my high school.

ANOVA[a]

| Model | | Sum of Squares | df | Mean Square | F | Sig. |
|---|---|---|---|---|---|---|
| 1 | Regression | .171 | 1 | .171 | 1.577 | .215[b] |
| | Residual | 5.969 | 55 | .109 | | |
| | Total | 6.140 | 56 | | | |

a. Dependent Variable: I have disclosed some of my mental illness experience to certain friends and classmates at my college.
b. Predictors: (Constant), I disclosed my mental illness to classmates at my high school.

The regression above shows that there is no significant association between disclosing to "certain friends and classmates" in high school as opposed to in college.

The p-value for the regression model that was run is p = .215 (not significant).

Table 6.12.2

*Disclosure to College Peers Predicts Disclosure to College Faculty*
(Survey questions Q9-13 and Q9-02)

Regression

Variables Entered/Removed[a]

| Model | Variables Entered | Variables Removed | Method |
|---|---|---|---|
| | I have disclosed some of my MI experience to certain classmates at my college.[b] | . | Enter |

a. Dependent Variable: I disclosed some of my MI experience to certain faculty or other staff at my college.
b. All requested variables entered.

Model Summary

| Model | R | R Square | Adjusted R Square | Std. Error of the Estimate |
|---|---|---|---|---|
| | .236[a] | .056 | .042 | .487 |

a. Predictors: (Constant), I have disclosed some of my MI experience to certain classmates at my college.

ANOVA[a]

| Model | | Sum of Squares | df | Mean Square | F | Sig. |
|---|---|---|---|---|---|---|
| | Regression | .967 | 1 | .967 | 4.078 | .047[b]* |
| | Residual | 16.357 | 69 | .237 | | |
| | Total | 17.324 | 70 | | | |

a. Dependent Variable: I disclosed some of my MI experience to certain faculty/staff at my college.
b. Predictors: (Constant), I have disclosed some of my MI exper. to certain classmates at college.

Coefficients[a]

| Model | | Unstandardized Coefficients B | Unstandardized Coefficients Std. Error | Standardized Coefficients Beta | t | Sig. |
|---|---|---|---|---|---|---|
| | (Constant) | 1.012 | .211 | | 4.787 | .000 |
| | I have disclosed some of my MI experience to certain classmates at my college. | .369 | .183 | .236 | 2.019 | .047* |

a. Dependent Variable: I disclosed some of my mental illness experience to certain faculty or other staff at my college.

*Note.* The regression above shows that there is a statistically significant relationship between mental health disclosures to college peers and mental health disclosures to college faculty. r = 2.36 and $r^2$=.056, meaning that the association is weak to moderate, and positive, and that changes in disclosure to college peers can account for 5.6% of the variance in disclosures to college faculty – a fairly small, yet significant, percentage.

The ANOVA shows that the p-value for the regression that was run is $p$ = .047. This indicates that, overall, the model predicts the outcome variable well (i.e., it is a good fit for the data). The Coefficients table provides the necessary information to both predict College Faculty disclosure from College Peer disclosure, and to to determine whether college peer disclosure contributes statistically significantly to the model (it does, as $p$ = .000). The regression equation is:

Y = a + bX

Dependent Variable = y-intercept +slope of line(Independent Variable)

Disclosure to College Faculty = 1.012 + .369(Disclosure to College Peers)

If disclosure to college peers increases by 1 point, then we can predict that disclosures to college faculty will increase by approximately .37 points.

*$p$ < .05

Table 6.12.3

*Disclosure to College Peers Does Not Predict use of Student Disability Services (SDS)*

(Survey questions Q9-13 and Q7-44)

Regression

Descriptive Statistics

| | Mean | Std. Deviation | N |
|---|---|---|---|
| Because of my MI, I have accessed services (e.g. academic accommodations) on my campus. | 1.54 | .502 | 65 |
| I have disclosed some of my MI experience to certain classmates at my college. | 1.08 | .269 | 65 |

Correlations

| | | Because of my MI, I have accessed services (e.g. acad. accomms.) on my campus. | I have disclosed some of my MI experience to certain classmates at my college. |
|---|---|---|---|
| Pearson Correlation | Because of my MI, I have accessed services (e.g. academic accommodations) on my campus. | 1.000 | .036 |
| | I have disclosed some of my MI experience to certain classmates at my college. | .036 | 1.000 |
| Sig. (1-tailed) | Because of my MI…on my campus. | . | .389 |
| | I have disclosed…at my college. | .389 | . |
| N | Because of my MI…on my campus. | 65 | 65 |
| | I have disclosed…at my college. | 65 | 65 |

Variables Entered/Removed[a]

| Model | Variables Entered | Variables Removed | Method |
|---|---|---|---|
| 1 | I have disclosed some of my MI experience to certain classmates at my college.[b] | . | Enter |

a. Dependent Variable: Because of my MI, I have accessed services (e.g. academic accommodations) on my campus.
b. All requested variables entered.

Model Summary

| Model | R | R Square | Adjusted R Square | Std. Error of the Estimate | Change Statistics | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | | | | | R Square Change | F Change | df1 | df2 | Sig. F Change |
| 1 | .036[a] | .001 | -.015 | .506 | .001 | .080 | 1 | 63 | .778 |

a. Predictors: (Constant), I have disclosed some of my MI experience to certain classmates at my college.

ANOVA[a]

| Model | | Sum of Squares | df | Mean Square | F | Sig. |
|---|---|---|---|---|---|---|
| 1 | Regression | .021 | 1 | .021 | .080 | .778[b] |
| | Residual | 16.133 | 63 | .256 | | |
| | Total | 16.154 | 64 | | | |

a. Dependent Variable: Because of my MI, I have accessed services (e.g. academic accommodations) on my campus.
b. Predictors: (Constant), I have disclosed some of my MI experience to certain friends and classmates at my college.

*Note.* The regression above shows that there is no significant relationship between mental health disclosures to college peers and use of on-campus Student Disability Services (e.g. in order to access academic accommodations).

The p-value for the regression that was run is $p = .778$ (not significant).

*$p < .05$

Table 6.12.4

*Disclosure to College Peers Predicts use of Campus Counseling and Psychological Services (CAPS)*
(Survey questions Q9-13 and Q7-57)

Regression

Descriptive Statistics

| | Mean | Std. Deviation | N |
|---|---|---|---|
| I have accessed resources or supports at my campus CAPS office. | 1.35 | .481 | 71 |
| I have disclosed some of my MI experience to certain classmates at my college. | 1.11 | .318 | 71 |

Correlations

| | | I have accessed resources or supports at my campus CAPS. | I disclosed some of my MI experience to certain classmates at my college. |
|---|---|---|---|
| Pearson Correlation | I have accessed resources or supports at my campus CAPS office. | 1.000 | .390 |
| | I have disclosed some of my MI experience to certain classmates at my college. | .390 | 1.000 |
| Sig. (1-tailed) | I have accessed resources or supports at my campus CAPS office. | . | .000 |
| | I have disclosed some of my MI experience to certain classmates at my college | .000 | . |
| N | I have accessed resources or supports at my campus CAPS office. | 71 | 71 |
| | I have disclosed some of my MI experience to certain classmates at my college. | 71 | 71 |

Variables Entered/Removed[a]

| Model | Variables Entered | Variables Removed | Method |
|---|---|---|---|
| 1 | I have disclosed some of my mental illness experience to certain friends and classmates at my col...[b] | . | Enter |

a. Dependent Variable: I have accessed resources or supports at my campus CAPS office.
b. All requested variables entered.

Model Summary

| Model | R | R Square | Adjusted R Square | Std. Error of the Estimate | Change Statistics R Square Change | F Change | df1 | df2 | Sig. F Change |
|---|---|---|---|---|---|---|---|---|---|
| 1 | .390[a] | .152 | .140 | .446 | .152 | 12.386 | 1 | 69 | .001** |

a. Predictors: (Constant), I have disclosed some of my MI experience to certain classmates at my college.

ANOVA[a]

| Model | | Sum of Squares | df | Mean Square | F | Sig. |
|---|---|---|---|---|---|---|
| 1 | Regression | 2.465 | 1 | 2.465 | 12.386 | .001[b]** |
| | Residual | 13.732 | 69 | .199 | | |
| | Total | 16.197 | 70 | | | |

a. Dependent Variable: I have accessed resources or supports at my campus CAPS office.

b. Predictors: (Constant), I have disclosed some of my MI experience to certain classmates at my college.

| Model | | Unstandardized Coefficients | | Standardized Coefficients | | |
|---|---|---|---|---|---|---|
| | | B | Std. Error | Beta | t | Sig. |
| 1 | (Constant) | .696 | .194 | | 3.596 | .001 |
| | I have disclosed some of my MI experience to certain classmates at my college. | .589 | .167 | .390 | 3.519 | .001 |

Note. The regression above shows that mental health disclosures to college peers predict use of on-campus Counseling and Psychological Services (CAPS). These two variables are positively, moderately, and significantly correlated ( r = .390 and $r^2$ = .152), and approximately 15% of the variance in use of CAPS can be explained by Disclosure to College Peers. The *p*-value for the regression model is $p = .001$, indicating that the model is a good fit for the data.

The coefficients table provides necessary information to predict Use of CAPS from College Peer Disclosure. The regression equation is:

Y = a + bX

Dependent Variable = y-intercept + slope of line (Independent Variable)

Use of CAPS = .696 + .589(Disc to Peers)

This equation represents a .59 point increase in use of CAPS (on a 5-point scale) for every 1-point increase in Disclosure.

** p < .01

**Disclosures in College Essays**

The next section of this chapter presents survey results related to why certain respondents elected to make mental health disclosures in their college application essays.

Table 6.13

*Reasons for Disclosures in College Application Essays - Frequencies*

| | to show the admissions committee that I have overcome a lot of challenges | because it is an important part of me | because it makes me different from the typical applicant | to support my interest in psychology …or some other mental health-related academic discipline | to explain why I had some academic struggles in high school | to explain why I had lots of absences in high school | to explain why I went to a therapeutic high school |
|---|---|---|---|---|---|---|---|
| # of Endorsements | 20 | 19 | 18 | 15 | 9 | 4 | 1 |
| % of College Essay Disclosers (n=23) | 87.0% | 82.6% | 78.3% | 65.2% | 39.1% | 17.4% | 4.3% |
| % of Total Sample (n=78) | 25.6% | 24.4% | 23.1% | 19.2% | 11.5% | 5.1% | 1.3% |

*Note.* A total of 23 respondents disclosed some aspect of their mental health history in their college application essays (29.5% of the total sample of 78). The above table displays frequencies of their reasons for making this type of disclosure, as well as percentages among other "college essay disclosers," as well as the broader sample. The above statements are multiple-choice, close-ended responses to the prompt "I mentioned my mental illness in my college application essay." Respondents were encouraged to "please select all that apply."

Twenty of the 23 respondents who disclosed claimed that their was decision was made "to show the admissions committee that [they] have overcome a lot of challenges"; 19 endorsed the reason "because it is an important part of me;" 18 claimed they wrote about it "because it makes [them] different from the typical applicant"; 15 disclosed in their essays to support an interest in psychology or other mental health-related field; 9 disclosed in their essays to explain "academic struggles"; 4 disclosed to explain "lots of

absences in high school"; and one respondent wrote about her experience as a way to explain her attendance at a therapeutic high school.

Bar Chart with Reasons for Disclosures in College Application Essay

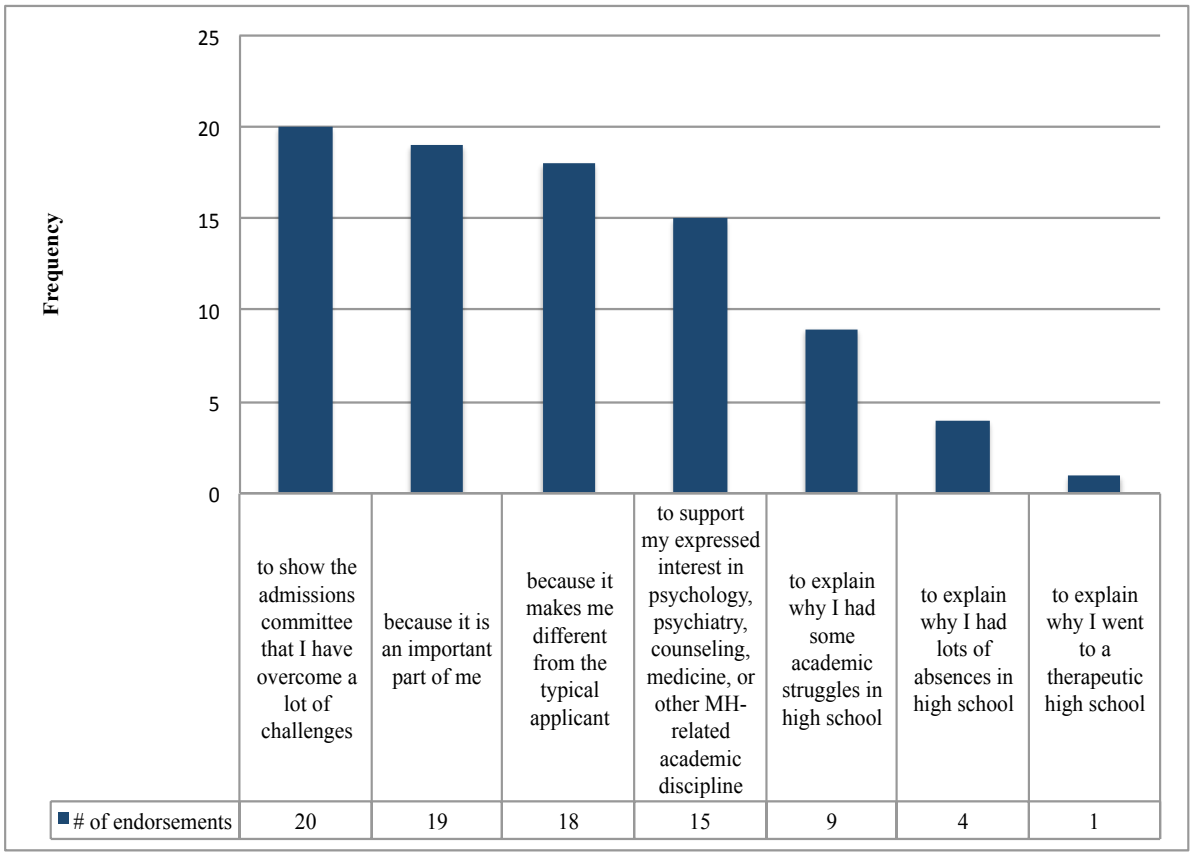



*Figure 6.8*. The above close-ended responses are to the prompt: "I mentioned my mental illness in my college application essay (please select all that apply)."

A total of 23 respondents disclosed in their college application essays. The above bar graph of frequencies represents the reasons given for doing this. (See Table 6.13 for more details on the percentage of College Essay Disclosers choosing each reason, above.)

**Reasons *Not* to Disclose**

The next section of this chapter displays results for reasons given not to make mental health disclosures in educational contexts. Table 6.14 displays reasons for not disclosing in high school, while Table 6.15 displays reasons for note disclosing in college. Figure 6.9.1 is a bar chart with frequencies for reasons not to disclose in college, and Figure 6.9.2 is a bar chart with comparing reasons not to disclose in high school versus college.

Table 6.14

*Reasons Not to Disclose in High School*

| For respondents who did not disclose at all in high school | n | % Non-Disclosers (n=20) | % total (n=78) |
|---|---|---|---|
| **Reasons not to disclose in HS** | | | |
| I was afraid that people would think less of me | 10 | 50.0 | 12.8 |
| If I had told one person, they might not have kept it a secret | 9 | 45.0 | 11.5 |
| It wasn't anyone's business | 9 | 45.0 | 11.5 |
| I didn't want to stand out as different | 8 | 40.0 | 10.3 |
| I didn't want any special treatment | 6 | 30.0 | 7.7 |
| I was afraid that I would lose friends | 5 | 25.0 | 6.4 |
| It wasn't a big deal. I was a HS student like everyone else. | 5 | 25.0 | 6.4 |
| It wasn't relevant because my MI probs started after HS | 1 | 5.0 | 1.3 |
| Other* | 6 | 30.0 | 7.7 |

***Other reasons not to disclose in HS** (open-ended responses, 6 total)

*Relational Reasons*

"I didn't have anyone to tell."

"If I disclosed I would have not been treated well."

*Symptoms made disclosure difficult*

"I was too anxious to talk to anyone."

*Lack of insight*

"I didn't really understand what I was going through."

"I didn't know I had mental health problems at the time, but looking back I see that I did."

*Didn't want pity*

"I didn't want people to pity me because I knew other people at my school had the same issues but had a more difficult time keeping their grades up."

Table 6.15

*Reasons not to Disclose in College*

| *For respondents who did not disclose at all in college* | Frequency | % Non-Disclosers (n=7) | % total sample (n=78) |
|---|---|---|---|
| **Reasons not to disclose in College** | | | |
| I don't want any special treatment | 5 | 71.4 | 6.4 |
| I don't want to stand out as different | 4 | 57.1 | 5.1 |
| I am afraid that people will think less of me | 4 | 57.1 | 5.1 |
| If I told someone, they might not keep it a secret and other people could find out | 4 | 57.1 | 5.1 |
| It's nobody's business | 3 | 42.9 | 3.8 |
| It's not a big deal. I am a college student like everyone else. | 3 | 42.9 | 3.8 |
| I am afraid that I would lose friends | 1 | 14.3 | 1.4 |
| Other* | 1 | 14.3 | 1.4 |

***Other reasons not to disclose in HS** (open-ended responses, 1 total)

*Don't believe that anyone would understand*

"No one has the time, everyone has their own problems to deal with, no one understands."

Reasons *Not* to Disclose in College

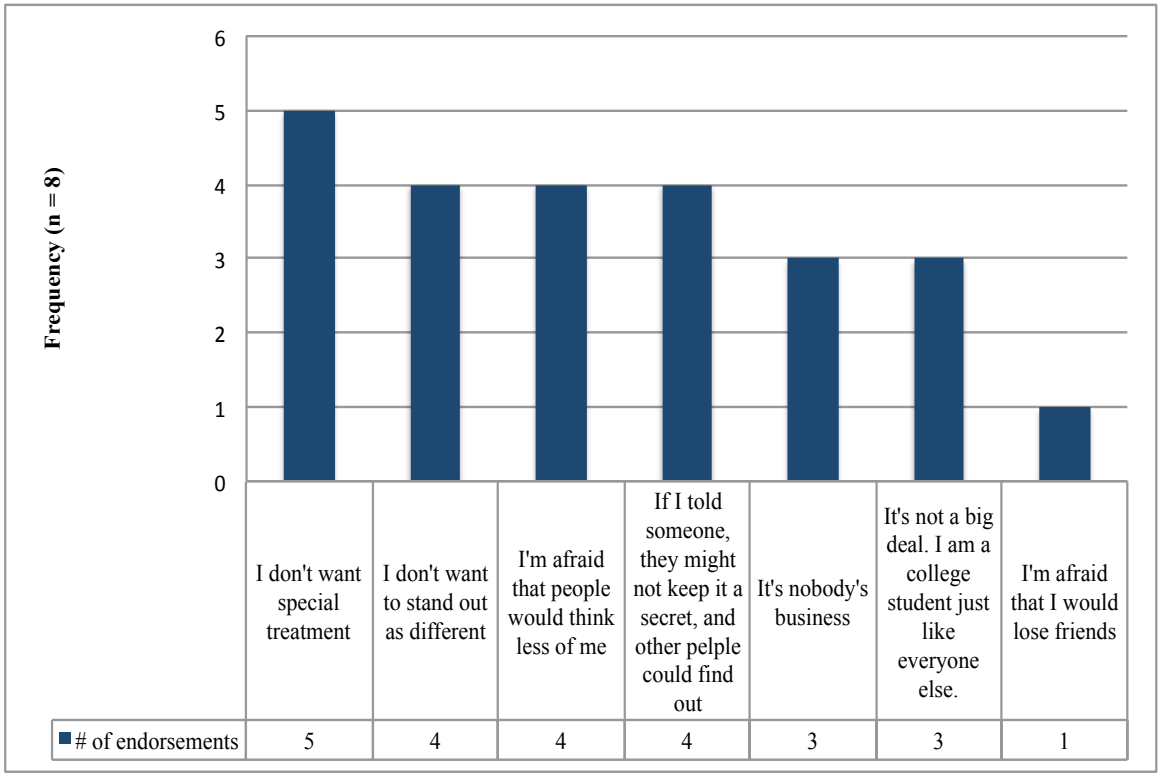



Figure 6.9.1. This bar chart depicts the reasons for not disclosing given by the 8 survey respondents who did not disclose to anyone in college. Respondents who selected "No" to the prompt "I disclosed some of my mental illness experience to certain friends and classmates at my college" (survey question Q9-13) were automatically taken to the end of the "College Disclosure" section and were asked to reflect on the reasons for keeping their mental health status private. Asked "What are the reasons that you have decided not to tell anyone at your college about your mental illness?" respondents were encouraged to "select all the apply" from the above seven statements.

Reasons *Not* to Disclose: High School vs. College

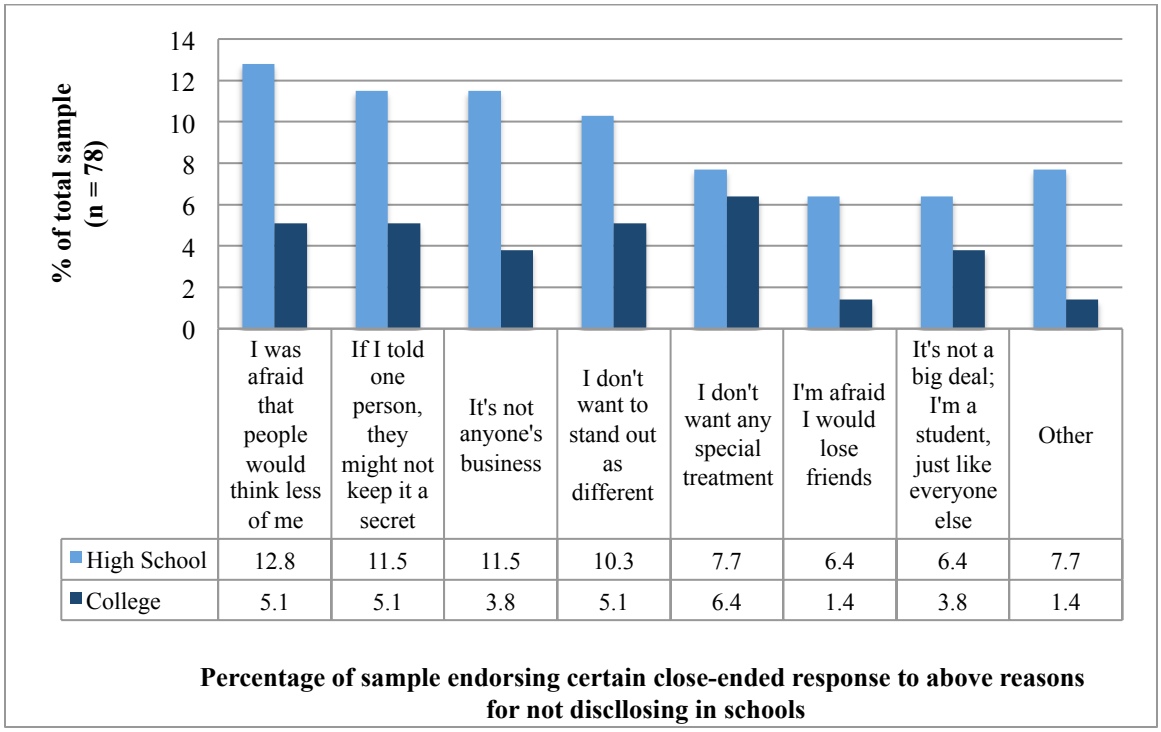



*Figure 6.9.2.* This bar chart depicts the percentages of reasons *not* to disclose given by the survey respondents who did not disclose to anyone in either high school and/or college. Respondents who selected "No" to the prompt "I disclosed some of my mental illness experience to certain friends and classmates " at my high school/college (survey questions Q5-13 and Q9-13, respectively) were automatically taken to the end of the "Disclosure" section of the survey and were asked to reflect on the reasons for keeping their mental health status private. Asked "What are the reasons that you have decided not to tell anyone at your school about your mental illness?" respondents were encouraged to "select all the apply" from the above eight statements.

*Recall from Figure 6.5.1 that a total of 21 survey respondents (27% of the total sample of 78) did not disclose to any peers at all in high school, while 15 (19%) did not

disclose to any peers in college. That said, the results in the current figure are from these "non-disclosers.

## Addressing RQ #3 Quantitatively: Relationships among Disclosure, Recovery, and Institutional Integration

The final section of this chapter addresses the relationships between and among disclosure, institutional integration (as measured by the IIS), and recovery (as measured by the RAS).

**Disclosure and Institutional Integration.** Table 6.15.1 displays central tendency scores for the IIS in aggregate, as well as for each if its subscales. Figure 6.10 is a bar chart depicting these IIS means, and comparing them with the possible high scores for each IIS subscale. Table 6.15.2 shows the results of a regression investigating the relationship between College Disclosure Computed (an over-all score of disclosure level in college) and institutional integration (the IIS total score). Tables 6.15.3 through 6.15.7 display results of regressions investigating the relationship between College Disclosure Computed and the five IIS subscales.

Table 6.15.1

Institutional Integration Scale (IIS): Total and Subscale Mean Scores

Frequencies

Statistics

| | | IIS TOTAL SCORE - Computed | Subscale 1: Peer Group Interactions | Subscale 2: Interactions w/ Faculty | Subscale 3: Faculty Concern for Student Development & Teaching | Subscale 4: Academic & Intellectual Dev. | Subscale 5: Institutional& Goal Commit-ments |
|---|---|---|---|---|---|---|---|
| N | Valid | 78 | 78 | 78 | 78 | 78 | 78 |
| | Missing | 1 | 1 | 1 | 1 | 1 | 1 |
| Mean | | 115.3205 | 25.1026 | 18.4615 | 18.6410 | 26.8590 | 26.2564 |
| Std. Error of Mean | | 1.71675 | .66914 | .45243 | .46128 | .60073 | .37104 |
| Median | | 114.0000 | 25.4667 | 18.5000 | 19.4286 | 28.0556 | 26.9412 |
| Mode | | 111.00 | 26.00 | 18.00 | 20.00 | 28.00 | 29.00 |
| Std. Dev | | 15.16189 | 5.90969 | 3.99575 | 4.07391 | 5.30553 | 3.27698 |
| Range | | 68.00 | 25.00 | 14.00 | 15.00 | 21.00 | 14.00 |
| Minimum | | 77.00 | 10.00 | 11.00 | 10.00 | 13.00 | 16.00 |
| Maximum | | 145.00 | 35.00 | 25.00 | 25.00 | 34.00 | 30.00 |

This Table shows the mean scores on the IIS for survey respondents, as well as mean scores for each of the five subscales on the instrument. The table also shows median and modal scores, as well as standard deviation, range, and minimum and maximum scores for the IIS total, as well as for each subscale.

*Note*. “IIS” is abbreviation for “Institutional Integration Scale”

Institutional Integration Scale: Subscale Means vs. Possible Scores

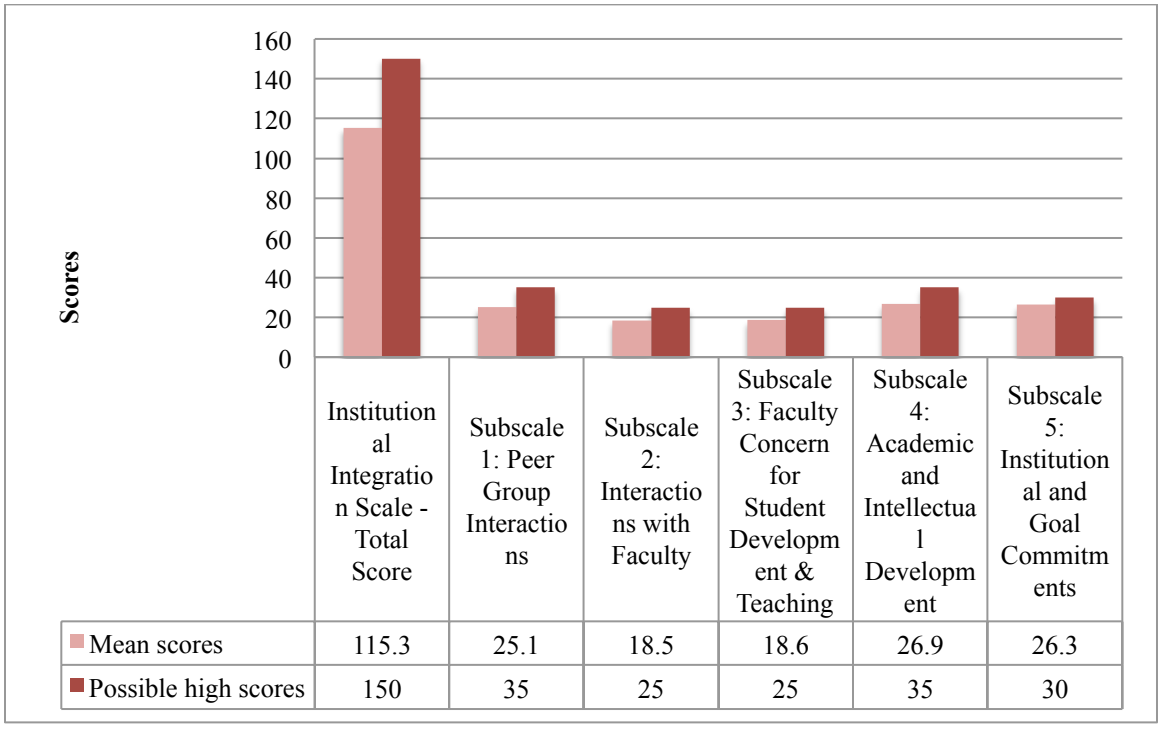



*Figure 6.10.* This Figure compares sample mean and possible high scores for the IIS in total, as well as for each of its five subscales. (See Table 6.13.1 for complete descriptive statistics.)

Table 6.15.2

*College Disclosure Computed Predicts IIS total score*

Correlations

Descriptive Statistics

| | Mean | Std. Deviation | N |
|---|---|---|---|
| COLL DISC – COMPUTED (survey Q9-45-A) | 13.4359 | 5.83004 | 78 |
| IIS TOTAL SCORE – COMPUTED (survey Q8-31) | 115.3205 | 15.16189 | 78 |

Correlations

| | | COLL DISC - COMPUTED | IIS TOTAL SCORE - COMPUTED |
|---|---|---|---|
| COLL DISC - COMPUTED | Pearson Correlation | 1 | .327 |
| | Sig. (2-tailed) | | .003** |
| | N | 78 | 78 |
| IIS TOTAL SCORE - COMPUTED | Pearson Correlation | .327** | 1 |
| | Sig. (2-tailed) | .003 | |
| | N | 78 | 78 |

**. Correlation is significant at the 0.01 level (2-tailed).

Model Summary

| | | | | | Change Statistics | | | | |
|---|---|---|---|---|---|---|---|---|---|
| Model | R | R Square | Adjusted R Square | Std. Error of the Estimate | R Square Change | F Change | df1 | df2 | Sig. F Change |
| 1 | .327[a] | .107 | .095 | 14.42121 | .107 | 9.113 | 1 | 76 | .003** |

a. Predictors: (Constant), COLL DISC - COMPUTED

ANOVA[a]

| Model | | Sum of Squares | df | Mean Square | F | Sig. |
|---|---|---|---|---|---|---|
| 1 | Regression | 1895.165 | 1 | 1895.165 | 9.113 | .003[b]** |
| | Residual | 15805.823 | 76 | 207.971 | | |
| | Total | 17700.987 | 77 | | | |

a. Dependent Variable: IIS TOTAL SCORE - COMPUTED
b. Predictors: (Constant), COLL DISC - COMPUTED

| | | Unstandardized Coefficients | | Standardized Coefficients | | |
|---|---|---|---|---|---|---|
| Model | | B | Std. Error | Beta | t | Sig. |
| 1 | (Constant) | 103.887 | 4.124 | | 25.188 | .000 |
| | COLL DISC - COMPUTED | .851 | .282 | .327 | 3.019 | .003** |

College Computed Score is positively, moderately, and significantly associated with total IIS score.

r = .327, $p$ = .003

$r^2$ = .107, $p$ = .003

Approximately 11% of the variance in total IIS score can be accounted for by the College disclosure computed score.

The regression equation is: IIS total score = 103.887 + .851(COLL-DISC COMP) If the COLL-DISC COMP score increases by 1 point, then the IIS total score will increase by approximately .851 points. If the COLL DISC COMP score is 0, then we predict that the IIS total score is 103.887.

**$p$ < .01

Table 6.15.3

*College Disclosure Computed Predicts IIS Subscale #1 "Peer Group Interactions"*

Regression

Descriptive Statistics

| | Mean | Std. Deviation | N |
|---|---|---|---|
| IIS Scale 1 sub-scale: PEER GRP INTERACTIONS (survey Q8-31-A) | 25.1026 | 5.90969 | 78 |
| COLL DISC – COMPUTED (survey Q9-45-A) | 13.4359 | 5.83004 | 78 |

Correlations

| | | IIS Scale 1 sub-score: PEER GRP INTERACTIONS | COLL DISC - COMPUTED |
|---|---|---|---|
| Pearson Correlation | IIS Scale 1 sub-scale: PEER GRP INTERACTIONS | 1.000 | .425 |
| | COLL DISC - COMPUTED | .425 | 1.000 |
| Sig. (1-tailed) | IIS Scale 1 sub-scale: PEER GRP INTERACTIONS | . | .000*** |
| | COLL DISC - COMPUTED | .000 | . |
| N | IIS Scale 1 sub-scale: PEER GRP INTERACTIONS | 78 | 78 |
| | COLL DISC - COMPUTED | 78 | 78 |

Model Summary

| | | | | | Change Statistics | | | | |
|---|---|---|---|---|---|---|---|---|---|
| Model | R | R Square | Adjusted R Square | Std. Error of the Estimate | R Square Change | F Change | df1 | df2 | Sig. F Change |
| 1 | .425[a] | .181 | .170 | 5.38447 | .181 | 16.754 | 1 | 76 | .000*** |

a. Predictors: (Constant), COLL DISC - COMPUTED

ANOVA[a]

| Model | | Sum of Squares | df | Mean Square | F | Sig. |
|---|---|---|---|---|---|---|
| 1 | Regression | 485.746 | 1 | 485.746 | 16.754 | .000[b]*** |
| | Residual | 2203.433 | 76 | 28.993 | | |
| | Total | 2689.179 | 77 | | | |

a. Dependent Variable: IIS Scale 1 sub-score: PEER GRP INTERACTIONS
b. Predictors: (Constant), COLL DISC - COMPUTED

Coefficients

| | | Unstandardized Coefficients | | Standardized Coefficients | | |
|---|---|---|---|---|---|---|
| Model | | B | Std. Error | Beta | t | Sig. |
| 1 | (Constant) | 19.314 | 1.540 | | 12.542 | .000 |
| | COLL DISC - COMPUTED | .431 | .105 | .425 | 4.093 | .000*** |

$r = .425$ , $p = .000$

COLL DISC COMP and IIS sub-scale #1 are positively, moderately, and significantly correlated.

$r^2 = .181$ , $p = .000$

Approximately 18% of the variance in IIS sub-scale #1, "Peer Group Interactions," can be explained by the COLL DISC COMP score.

***$p < .001$

The regression equation is: Peer Group Interactions = 19.314 + .431 (COLL DISC COMP)

For every 1-point increase in COLL DISC COMP score, there is a .431 point increase in Peer Group Interaction sub-scale score.

Table 6.15.4

*College Disclosure Computed predicts IIS Subscale #2 "Interactions with Faculty"*

Regression

Descriptive Statistics

| | Mean | Std. Deviation | N |
|---|---|---|---|
| IIS Scale 2 sub-score: INTERACTIONS w/ FACULTY (survey Q8-31-B) | 18.4615 | 3.99575 | 78 |
| COLL DISC – COMPUTED (survey Q9-45-A) | 13.4359 | 5.83004 | 78 |

Correlations

| | | IIS Scale 2 sub-score: INTERAC-TIONS w/ FACULTY | COLL DISC - COMPUTED |
|---|---|---|---|
| Pearson Correlation | IIS Scale 2 sub-score: INTERACTIONS w/ FACULTY | 1.000 | .406 |
| | COLL DISC - COMPUTED | .406 | 1.000 |
| Sig. (1-tailed) | IIS Scale 2 sub-score: INTERACTIONS w/ FACULTY | . | .000*** |
| | COLL DISC - COMPUTED | .000 | . |
| N | IIS Scale 2 sub-score: INTERACTIONS w/ FACULTY | 78 | 78 |
| | COLL DISC - COMPUTED | 78 | 78 |

Model Summary

| | | | | | Change Statistics | | | | |
|---|---|---|---|---|---|---|---|---|---|
| Model | R | R Square | Adjusted R Square | Std. Error of the Estimate | R Square Change | F Change | df1 | df2 | Sig. F Change |
| 1 | .406[a] | .165 | .154 | 3.67551 | .165 | 15.002 | 1 | 76 | .000*** |

a. Predictors: (Constant), COLL DISC - COMPUTED

ANOVA[a]

| Model | | Sum of Squares | df | Mean Square | F | Sig. |
|---|---|---|---|---|---|---|
| 1 | Regression | 202.673 | 1 | 202.673 | 15.002 | .000[b]*** |
| | Residual | 1026.711 | 76 | 13.509 | | |
| | Total | 1229.385 | 77 | | | |

a. Dependent Variable: IIS Scale 2 sub-score: INTERACTIONS w/ FACULTY
b. Predictors: (Constant), COLL DISC - COMPUTED

Coefficients

| Model | | Unstandardized Coefficients | | Standardized Coefficients | | |
|---|---|---|---|---|---|---|
| | | B | Std. Error | Beta | t | Sig. |
| 1 | (Constant) | 14.723 | 1.051 | | 14.006 | .000 |
| | COLL DISC - COMPUTED | .278 | .072 | .406 | 3.873 | .000*** |

r = .406, $p$ = .000***

COLL DISC COMP and IIS subscale #2 are positively, moderately, and significantly correlated.

$r^2$ = .165, $p$ = .000***

Approximately 16.5% of the variance in IIS subscale #2 can be explained by the COLL DISC COMP score.

The regression equation is: "Interactions with Faculty" = 14.723 + .278 (COLL DISC COMP). For every 1-point increase in the COLL DISC COMP score, there is a .278 point increase in the IIS sub-scale #2 score.

*** p < .001

Table 6.15.5

*College Disclosure Computed does not predict IIS sub-scale #3: "Faculty Concern for Student Development and Teaching"*

Regression

Descriptive Statistics

| | Mean | Std. Deviation | N |
|---|---|---|---|
| IIS Scale 3 sub-score: FACULTY CONCERN for STUDENT DEV and TEACHING | 18.6410 | 4.07391 | 78 |
| COLL DISC - COMPUTED | 13.4359 | 5.83004 | 78 |

Correlations

| | | IIS Scale 3 sub-score: FACULTY CONCERN for STUDENT DEV and TEACHING | COLL DISC - COMPUTED |
|---|---|---|---|
| Pearson Correlation | IIS Scale 3 sub-score: FACULTY CONCERN for STUDENT DEV and TEACHING | 1.000 | .095 |
| | COLL DISC - COMPUTED | .095 | 1.000 |
| Sig. (1-tailed) | IIS Scale 3 sub-score: FACULTY CONCERN for STUDENT DEV and TEACHING | . | .205 |
| | COLL DISC - COMPUTED | .205 | . |
| N | IIS Scale 3 sub-score: FACULTY CONCERN for STUDENT DEV and TEACHING | 78 | 78 |
| | COLL DISC - COMPUTED | 78 | 78 |

Model Summary

| | | | | | Change Statistics | | | | |
|---|---|---|---|---|---|---|---|---|---|
| Model | R | R Square | Adjusted R Square | Std. Error of the Estimate | R Square Change | F Change | df1 | df2 | Sig. F Change |
| 1 | .095[a] | .009 | -.004 | 4.08219 | .009 | .688 | 1 | 76 | .409 |

a. Predictors: (Constant), COLL DISC - COMPUTED

ANOVA[a]

| Model | | Sum of Squares | df | Mean Square | F | Sig. |
|---|---|---|---|---|---|---|
| 1 | Regression | 11.463 | 1 | 11.463 | .688 | .409[b] |
| | Residual | 1266.486 | 76 | 16.664 | | |
| | Total | 1277.949 | 77 | | | |

a. Dependent Variable: IIS Scale 3 sub-score: FACULTY CONCERN for STUDENT DEV and TEACHING
b. Predictors: (Constant), COLL DISC - COMPUTED

Coefficients[a]

| Model | | Unstandardized Coefficients | | Standardized Coefficients | | |
|---|---|---|---|---|---|---|
| | | B | Std. Error | Beta | t | Sig. |
| 1 | (Constant) | 17.752 | 1.168 | | 15.205 | .000 |
| | COLL DISC - COMPUTED | .066 | .080 | .095 | .829 | .409 |

Dependent Variable: IIS Scale 3 sub-score: FACULTY CONCNER FOR STUDENT DEV and TEACHING

r = .095, $p$ = .205

$r^2$ = .009, $p$ = .409

There is no significant correlation between COLL DISC COMP and IIS sub-scale #3.

Table 6.15.6

*College Disclosure Computed does not predict IIS sub-scale #4 "Academic and Intellectual Development"*

Regression

Descriptive Statistics

| | Mean | Std. Deviation | N |
|---|---|---|---|
| IIS Scale 4 sub-score: ACAD and INTELLECTUAL DEV (survey Q8-31-D) | 26.8590 | 5.30553 | 78 |
| COLL DISC – COMPUTED (survey Q9-45-A) | 13.4359 | 5.83004 | 78 |

Correlations

| | | IIS Scale 4 sub-score: ACAD and INTELLECTUAL DEV | COLL DISC - COMPUTED |
|---|---|---|---|
| Pearson Correlation | IIS Scale 4 sub-score: ACAD and INTELLECTUAL DEV | 1.000 | .175 |
| | COLL DISC - COMPUTED | .175 | 1.000 |
| Sig. (1-tailed) | IIS Scale 4 sub-score: ACAD and INTELLECTUAL DEV | . | .063 |
| | COLL DISC - COMPUTED | .063 | . |
| N | IIS Scale 4 sub-score: ACAD and INTELLECTUAL DEV | 78 | 78 |
| | COLL DISC - COMPUTED | 78 | 78 |

Model Summary

| | | | | | Change Statistics | | | | |
|---|---|---|---|---|---|---|---|---|---|
| Model | R | R Square | Adjusted R Square | Std. Error of the Estimate | R Square Change | F Change | df1 | df2 | Sig. F Change |
| 1 | .175[a] | .030 | .018 | 5.25832 | .030 | 2.389 | 1 | 76 | .126 |

a. Predictors: (Constant), COLL DISC - COMPUTED

**ANOVA[a]**

| Model | | Sum of Squares | df | Mean Square | F | Sig. |
|---|---|---|---|---|---|---|
| 1 | Regression | 66.058 | 1 | 66.058 | 2.389 | .126[b] |
| | Residual | 2101.391 | 76 | 27.650 | | |
| | Total | 2167.449 | 77 | | | |

a. Dependent Variable: IIS Scale 4 sub-score: ACAD and INTELLECTUAL DEV
b. Predictors: (Constant), COLL DISC - COMPUTED

Coefficients

| | | Unstandardized Coefficients | | Standardized Coefficients | | |
|---|---|---|---|---|---|---|
| Model | | B | Std. Error | Beta | t | Sig. |
| 1 | (Constant) | 24.724 | 1.504 | | 16.440 | .000 |
| | COLL DISC - COMPUTED | .159 | .103 | .175 | 1.546 | .126 |

r =.175, $p$ = .06

$r^2$ = .030, $p$ = .126

There is no significant correlation between COLL DISC COMP and IIS sub-scale #4.

Table 6.15.7

*College Disclosure Computed does not predict IIS sub-scale #5 "Institutional and Goal Commitments"*

Regression

Descriptive Statistics

| | Mean | Std. Deviation | N |
|---|---|---|---|
| IIS Scale 5 sub-score: INSTITUTIONAL and GOAL COMMITMENTS (survey Q8-31-E) | 26.2564 | 3.27698 | 78 |
| COLL DISC – COMPUTED (survey Q9-45-A) | 13.4359 | 5.83004 | 78 |

Correlations

| | | IIS Scale 5 sub-score: INSTITUTIONAL and GOAL COMMITMENTS | COLL DISC - COMPUTED |
|---|---|---|---|
| Pearson Correlation | IIS Scale 5 sub-score: INSTITUTIONAL and GOAL COMMITMENTS | 1.000 | -.148 |
| | COLL DISC - COMPUTED | -.148 | 1.000 |
| Sig. (1-tailed) | IIS Scale 5 sub-score: INSTITUTIONAL and GOAL COMMITMENTS | . | .098 |
| | COLL DISC - COMPUTED | .098 | . |
| N | IIS Scale 5 sub-score: INSTITUTIONAL and GOAL COMMITMENTS | 78 | 78 |
| | COLL DISC - COMPUTED | 78 | 78 |

Model Summary

| | | | | | Change Statistics | | | | |
|---|---|---|---|---|---|---|---|---|---|
| Model | R | R Square | Adjusted R Square | Std. Error of the Estimate | R Square Change | F Change | df1 | df2 | Sig. F Change |
| 1 | .148[a] | .022 | .009 | 3.26214 | .022 | 1.702 | 1 | 76 | .196 |

a. Predictors: (Constant), COLL DISC - COMPUTED

ANOVA[a]

| Model | | Sum of Squares | df | Mean Square | F | Sig. |
|---|---|---|---|---|---|---|
| 1 | Regression | 18.112 | 1 | 18.112 | 1.702 | .196[b] |
| | Residual | 808.760 | 76 | 10.642 | | |
| | Total | 826.872 | 77 | | | |

a. Dependent Variable: IIS Scale 5 sub-score: INSTITUTIONAL and GOAL COMMITMENTS

b. Predictors: (Constant), COLL DISC - COMPUTED

Coefficients

| Model | | Unstandardized Coefficients | | Standardized Coefficients | | |
|---|---|---|---|---|---|---|
| | | B | Std. Error | Beta | t | Sig. |
| 1 | (Constant) | 27.374 | .933 | | 29.341 | .000 |
| | COLL DISC - COMPUTED | -.083 | .064 | -.148 | -1.305 | .196 |

r = -.148, $p$ = .098

$r^2$ = .022 , $p$ = .196

There is no significant correlation between COLL DISC COMP and IIS subscale #5.

**Disclosure and Recovery**

Table 6.16.1 displays central tendency scores for the RAS in aggregate, as well as for each if its subscales. Figure 6.11.1 is a bar chart depicting these RAS means, and comparing them with the possible high scores for each RAS subscale. Table 6.16.2 shows the results of a regression investigating the relationship between College Disclosure Computed (an over-all score of disclosure level in college) and recovery (the RAS total score). Tables 6.16.3 through 6.16.7 display results of regressions investigating the relationship between College Disclosure Computed and the five RAS subscales.

Table 6.16.1

Recovery Assessment Scale (RAS): Total and Subscale Mean Scores

Frequencies

Statistics

| | | RAS - TOTAL SCORE | Subscale 1: Personal Confidence & Hope | Subscale 2: Willingness to Ask for Help | Subscale 3: Goal & Success Orientation | Subscale 4: Reliance on Others | Subscale 5: Not Dominated by Symptoms |
|---|---|---|---|---|---|---|---|
| N | Valid | 78 | 78 | 78 | 78 | 78 | 78 |
| | Missing | 1 | 1 | 1 | 1 | 1 | 1 |
| Mean | | 92.7692 | 33.1667 | 11.3974 | 21.4615 | 16.5769 | 10.1667 |
| Std. Error of Mean | | 1.71785 | .79258 | .33516 | .37250 | .28418 | .35592 |
| Median | | 94.1667[a] | 33.2500[a] | 11.6875[a] | 22.2000[a] | 16.9167[a] | 10.6111[a] |
| Mode | | 99.00 | 31.00 | 12.00[b] | 25.00 | 17.00 | 12.00 |
| Std. Deviation | | 15.17168 | 6.99985 | 2.96008 | 3.28986 | 2.50982 | 3.14340 |
| Range | | 71.00 | 33.00 | 14.00 | 13.00 | 9.00 | 12.00 |
| Minimum | | 49.00 | 12.00 | 4.00 | 12.00 | 11.00 | 3.00 |
| Maximum | | 120.00 | 45.00 | 18.00 | 25.00 | 20.00 | 15.00 |

This table shows the mean scores on the RAS for survey respondents, as well as mean scores for each of the five subscales on the instrument. That table also shows median and modal scores, as well as standard deviation, range, and minimum and maximum scores for the IIS total, as well as for each subscale.

*Note.* "RAS" is abbreviation for "Recovery Assessment Scale"

Recovery Assessment Scale (RAS): Sub-scale possible scores vs. mean scores

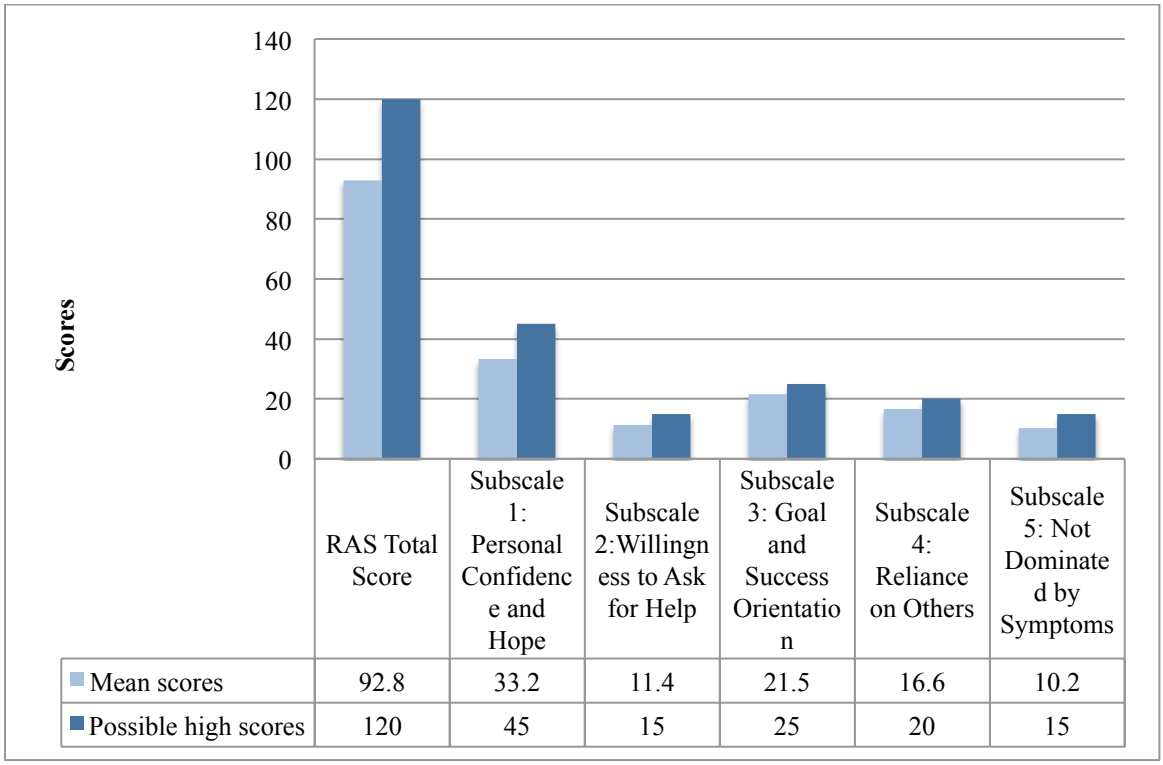



*Figure 6.11.1.* This figure compares sample mean and possible high scores for the RAS in total, as well as for each of its five subscales. (See Table 6.14.1 for complete descriptive statistics.)

Table 6.16.2

College Disclosure Computed score predicts total RAS score

Descriptive Statistics

| | Mean | Std. Deviation | N |
|---|---|---|---|
| COLL DISC - COMPUTED | 13.4359 | 5.83004 | 78 |
| RAS - TOTAL SCORE | 92.7692 | 15.17168 | 78 |

Correlations

| | | COLL DISC - COMPUTED | RAS - TOTAL SCORE |
|---|---|---|---|
| COLL DISC - COMPUTED | Pearson Correlation | 1 | .387*** |
| | Sig. (2-tailed) | | .000 |
| | N | 78 | 78 |
| RAS - TOTAL SCORE | Pearson Correlation | .387** | 1 |
| | Sig. (2-tailed) | .000 | |
| | N | 78 | 78 |

***. Correlation is significant at the 0.001 level (2-tailed).

Model Summary

| Model | R | R Square | Adjusted R Square | Std. Error of the Estimate | Change Statistics R Square Change | F Change | df1 | df2 | Sig. F Change |
|---|---|---|---|---|---|---|---|---|---|
| 1 | .387[a] | .150 | .139 | 14.07833 | .150 | 13.424 | 1 | 76 | .000*** |

a. Predictors: (Constant), COLL DISC - COMPUTED

ANOVA[a]

| Model | | Sum of Squares | df | Mean Square | F | Sig. |
|---|---|---|---|---|---|---|
| 1 | Regression | 2660.692 | 1 | 2660.692 | 13.424 | .000[b] |
| | Residual | 15063.154 | 76 | 198.199 | | |
| | Total | 17723.846 | 77 | | | |

a. Dependent Variable: RAS - TOTAL SCORE
b. Predictors: (Constant), COLL DISC - COMPUTED

| Model | | Unstandardized Coefficients B | Unstandardized Coefficients Std. Error | Standardized Coefficients Beta | t | Sig. |
|---|---|---|---|---|---|---|
| 1 | (Constant) | 79.222 | 4.026 | | 19.676 | .000 |
| | COLL DISC - COMPUTED | 1.008 | .275 | .387 | 3.664 | .000 |

r = .387, p = .000

College Disclosure Computed and RAS total scores are positively, moderately, and significantly correlated.

$r^2 = .150$, $p = .000$

Approximately 15% of the variance in RAS total score can be explained by College Computed Disclosure score.

The regression equation for the relationship between these two variables is:

RAS total score = 79.222 + 1.008 (COLL DISC COMPUTED).

For every one-point increase in College Disclosure Computed score, there will be a 1.008 point increase in RAS total score. And if College Disclosure Computed score is zero "0," then RAS total score would be 79.222.

Table 6.16.3

*College Disclosure Computed predicts RAS Subscale #1 "Personal Confidence and Hope"*

Regression

Descriptive Statistics

| | Mean | Std. Deviation | N |
|---|---|---|---|
| RAS subscale 1: PERSONAL CONFIDENCE & HOPE (survey Q10-24-A) | 33.1667 | 6.99985 | 78 |
| COLL DISC – COMPUTED (survey Q9-45-A) | 13.4359 | 5.83004 | 78 |

Correlations

| | | RAS subscale 1: PERSONAL CONFIDENCE & HOPE | COLL DISC - COMPUTED |
|---|---|---|---|
| Pearson Correlation | RAS subscale 1: PERSONAL CONFIDENCE & HOPE | 1.000 | .384** |
| | COLL DISC - COMPUTED | .384 | 1.000 |
| Sig. (1-tailed) | RAS subscale 1: PERSONAL CONFIDENCE & HOPE | . | .000 |
| | COLL DISC - COMPUTED | .000 | . |
| N | RAS subscale 1: PERSONAL CONFIDENCE & HOPE | 78 | 78 |
| | COLL DISC - COMPUTED | 78 | 78 |

Model Summary

| | | | | | Change Statistics | | | | |
|---|---|---|---|---|---|---|---|---|---|
| Model | R | R Square | Adjusted R Square | Std. Error of the Estimate | R Square Change | F Change | df1 | df2 | Sig. F Change |
| 1 | .384[a] | .147 | .136 | 6.50587 | .147 | 13.137 | 1 | 76 | .001** |

a. Predictors: (Constant), COLL DISC - COMPUTED

ANOVA[a]

| Model | | Sum of Squares | df | Mean Square | F | Sig. |
|---|---|---|---|---|---|---|
| 1 | Regression | 556.034 | 1 | 556.034 | 13.137 | .001[b]** |
| | Residual | 3216.800 | 76 | 42.326 | | |
| | Total | 3772.833 | 77 | | | |

a. Dependent Variable: RAS subscale 1: PERSONAL CONFIDENCE & HOPE
b. Predictors: (Constant), COLL DISC - COMPUTED

Coefficients

| | | Unstandardized Coefficients | | Standardized Coefficients | | |
|---|---|---|---|---|---|---|
| Model | | B | Std. Error | Beta | t | Sig. |
| 1 | (Constant) | 26.974 | 1.861 | | 14.497 | .000 |
| | COLL DISC - COMPUTED | .461 | .127 | .384 | 3.624 | .001** |

$r = .384$, $p = .001$

College Disclosure Computed and “Personal Confidence & Hope” sub-scale of RAS as positively, moderately, and significantly correlated.

$r^2 = .147$

College Disclosure Computed score explains approximately 14.7% of the variance in “Personal Confidence & Hope” sub-scale of the RAS

** $p < .01$

The regression equation for the relationship between COLL DISC COMP and RAS subscale #1 is: Personal Confidence & Hope = 26.974 + .461(COLL DISC COMP)

Table 6.16.4

*College Disclosure Computed predicts RAS Subscale #2 "Willingness to Ask for Help"*

Regression

Descriptive Statistics

| | Mean | Std. Deviation | N |
|---|---|---|---|
| RAS subscale 2: WILLINGNESS TO ASK FOR HELP (survey Q10-24-B) | 11.3974 | 2.96008 | 78 |
| COLL DISC – COMPUTED (survey Q9-45-A) | 13.4359 | 5.83004 | 78 |

Correlations

| | | RAS subscale 2: WILLINGNESS TO ASK FOR HELP | COLL DISC - COMPUTED |
|---|---|---|---|
| Pearson Correlation | RAS subscale 2: WILLINGNESS TO ASK FOR HELP | 1.000 | .246 |
| | COLL DISC - COMPUTED | .246 | 1.000 |
| Sig. (1-tailed) | RAS subscale 2: WILLINGNESS TO ASK FOR HELP | . | .015* |
| | COLL DISC - COMPUTED | .015 | . |
| N | RAS subscale 2: WILLINGNESS TO ASK FOR HELP | 78 | 78 |
| | COLL DISC - COMPUTED | 78 | 78 |

Model Summary

| Model | R | R Square | Adjusted R Square | Std. Error of the Estimate | Change Statistics R Square Change | F Change | df1 | df2 | Sig. F Change |
|---|---|---|---|---|---|---|---|---|---|
| 1 | .246[a] | .060 | .048 | 2.88816 | .060 | 4.883 | 1 | 76 | .030* |

a. Predictors: (Constant), COLL DISC - COMPUTED

ANOVA[a]

| Model | | Sum of Squares | df | Mean Square | F | Sig. |
|---|---|---|---|---|---|---|
| 1 | Regression | 40.729 | 1 | 40.729 | 4.883 | .030[b]* |
| | Residual | 633.951 | 76 | 8.341 | | |
| | Total | 674.679 | 77 | | | |

a. Dependent Variable: RAS subscale 2: WILLINGNESS TO ASK FOR HELP
b. Predictors: (Constant), COLL DISC – COMPUTED

| Model | | Unstandardized Coefficients B | Unstandardized Coefficients Std. Error | Standardized Coefficients Beta | t | Sig. |
|---|---|---|---|---|---|---|
| 1 | (Constant) | 9.721 | .826 | | 11.769 | .000 |
| | COLL DISC - COMPUTED | .125 | .056 | .246 | 2.210 | .030* |

r = .246 , $p$ = .030

COLL COM-DISC and “Willingness to Ask for Help” are positively, weakly, and significantly correlated.

$r^2$ = .06 Approximately 6% of the variance in RAS sub-scale #2 scores can be explained by the COLL DISC-COMP score.

The regression equation for the relationship between COLL DISC – COMPUTED and RAS sub-scale #2 is: “Willingness to Ask for Help” = 9.721 + .125 (COLL DISC – COMP)

For every 1-point increase in COLL DISC COMP, there will be a .125 point increase in the sub-scale score.

*$p$ < .05

Table 6.16.5

*College Disclosure Computed predicts RAS Sub-scale #3 "Goal and Success Orientation"*

Regression

Descriptive Statistics

| | Mean | Std. Deviation | N |
|---|---|---|---|
| RAS subscale 3: GOAL & SUCCESS ORIENTATION | 21.4615 | 3.28986 | 78 |
| COLL DISC - COMPUTED | 13.4359 | 5.83004 | 78 |

Correlations

| | | RAS subscale 3: GOAL & SUCCESS ORIENTATION | COLL DISC - COMPUTED |
|---|---|---|---|
| Pearson Correlation | RAS subscale 3: GOAL & SUCCESS ORIENTATION | 1.000 | .249 |
| | COLL DISC - COMPUTED | .249 | 1.000 |
| Sig. (1-tailed) | RAS subscale 3: GOAL & SUCCESS ORIENTATION | . | .014* |
| | COLL DISC - COMPUTED | .014 | . |
| N | RAS subscale 3: GOAL & SUCCESS ORIENTATION | 78 | 78 |
| | COLL DISC - COMPUTED | 78 | 78 |

Model Summary

| | | | | | Change Statistics | | | | |
|---|---|---|---|---|---|---|---|---|---|
| Model | R | R Square | Adjusted R Square | Std. Error of the Estimate | R Square Change | F Change | df1 | df2 | Sig. F Change |
| 1 | .249[a] | .062 | .050 | 3.20738 | .062 | 5.011 | 1 | 76 | .028* |

a. Predictors: (Constant), COLL DISC - COMPUTED

ANOVA[a]

| Model | | Sum of Squares | df | Mean Square | F | Sig. |
|---|---|---|---|---|---|---|
| 1 | Regression | 51.550 | 1 | 51.550 | 5.011 | .028[b]* |
| | Residual | 781.835 | 76 | 10.287 | | |
| | Total | 833.385 | 77 | | | |

a. Dependent Variable: RAS subscale 3: GOAL & SUCCESS ORIENTATION
b. Predictors: (Constant), COLL DISC - COMPUTED

| | | Unstandardized Coefficients | | Standardized Coefficients | | |
|---|---|---|---|---|---|---|
| Model | | B | Std. Error | Beta | t | Sig. |
| 1 | (Constant) | 19.576 | .917 | | 21.340 | .000 |
| | COLL DISC - COMPUTED | .140 | .063 | .249 | 2.239 | .028* |

r = .249, $p$ = .014

COLL DISC-COMP and Ras sub-scale #3 are positively, weakly, and significantly correlated.

$r^2 = .062$, $p = .028$

Approximately 6.2% of the variance in RAS sub-scale #3 can be explained by COLL DISC COMP.

Regression equation: "Goal & Success Orientation" = 19.576 + .140(COLL DISC-COMP)

*$p < .05$

Table 6.16.6

*College Disclosure Computed predicts RAS Sub-scale #4 "Reliance on Others"*

Regression

Descriptive Statistics

| | Mean | Std. Deviation | N |
|---|---|---|---|
| RAS subscale 4: RELIANCE ON OTHERS | 16.5769 | 2.50982 | 78 |
| COLL DISC - COMPUTED | 13.4359 | 5.83004 | 78 |

Correlations

| | | RAS subscale 4: RELIANCE ON OTHERS | COLL DISC - COMPUTED |
|---|---|---|---|
| Pearson Correlation | RAS subscale 4: RELIANCE ON OTHERS | 1.000 | .285 |
| | COLL DISC - COMPUTED | .285 | 1.000 |
| Sig. (1-tailed) | RAS subscale 4: RELIANCE ON OTHERS | . | .006** |
| | COLL DISC - COMPUTED | .006 | . |
| N | RAS subscale 4: RELIANCE ON OTHERS | 78 | 78 |
| | COLL DISC - COMPUTED | 78 | 78 |

Model Summary

| | | | | | Change Statistics | | | | |
|---|---|---|---|---|---|---|---|---|---|
| Model | R | R Square | Adjusted R Square | Std. Error of the Estimate | R Square Change | F Change | df1 | df2 | Sig. F Change |
| 1 | .285[a] | .081 | .069 | 2.42132 | .081 | 6.731 | 1 | 76 | .011* |

a. Predictors: (Constant), COLL DISC - COMPUTED

ANOVA[a]

| Model | | Sum of Squares | df | Mean Square | F | Sig. |
|---|---|---|---|---|---|---|
| 1 | Regression | 39.465 | 1 | 39.465 | 6.731 | .011[b]* |
| | Residual | 445.573 | 76 | 5.863 | | |
| | Total | 485.038 | 77 | | | |

a. Dependent Variable: RAS subscale 4: RELIANCE ON OTHERS
b. Predictors: (Constant), COLL DISC - COMPUTED

Coefficients

| | | Unstandardized Coefficients | | Standardized Coefficients | | |
|---|---|---|---|---|---|---|
| Model | | B | Std. Error | Beta | t | Sig. |
| 1 | (Constant) | 14.927 | .693 | | 21.555 | .000 |
| | COLL DISC - COMPUTED | .123 | .047 | .285 | 2.595 | .011 |

r = .285, $p$ = .006**

COLL DISC COMP and RAS subscale #4 are positively, weakly, and significantly correlated.

$r^2$ = .081, $p$ = .011*

Approximately 8.1% of the variance in RAS subscale #4 can be explained by COLL DISC

COMP.

The regression equation is: “Reliance on Others” = 14.927 + .123(COLL DISC COMP)

*p < .05, ** p < .01

Table 6.16.7

*College Disclosure Computed predicts RAS Sub-scale #5 "Not Dominated by Symptoms"*

Regression

Descriptive Statistics

| | Mean | Std. Deviation | N |
|---|---|---|---|
| RAS subscale 5: NOT DOMINATED BY SYMPTOMS (survey Q10-24-E) | 10.1667 | 3.14340 | 78 |
| COLL DISC – COMPUTED (survey Q9-45-A) | 13.4359 | 5.83004 | 78 |

Correlations

| | | RAS subscale 5: NOT DOMINATED BY SYMPTOMS | COLL DISC - COMPUTED |
|---|---|---|---|
| Pearson Correlation | RAS subscale 5: NOT DOMINATED BY SYMPTOMS | 1.000 | .296 |
| | COLL DISC - COMPUTED | .296 | 1.000 |
| Sig. (1-tailed) | RAS subscale 5: NOT DOMINATED BY SYMPTOMS | . | .004** |
| | COLL DISC - COMPUTED | .004 | . |
| N | RAS subscale 5: NOT DOMINATED BY SYMPTOMS | 78 | 78 |
| | COLL DISC - COMPUTED | 78 | 78 |

Model Summary

| | | | | | Change Statistics | | | | |
|---|---|---|---|---|---|---|---|---|---|
| Model | R | R Square | Adjusted R Square | Std. Error of the Estimate | R Square Change | F Change | df1 | df2 | Sig. F Change |
| 1 | .296[a] | .087 | .075 | 3.02247 | .087 | 7.285 | 1 | 76 | .009** |

a. Predictors: (Constant), COLL DISC - COMPUTED

ANOVA[a]

| Model | | Sum of Squares | df | Mean Square | F | Sig. |
|---|---|---|---|---|---|---|
| 1 | Regression | 66.548 | 1 | 66.548 | 7.285 | .009[b]** |
| | Residual | 694.286 | 76 | 9.135 | | |
| | Total | 760.833 | 77 | | | |

a. Dependent Variable: RAS subscale 5: NOT DOMINATED BY SYMPTOMS
b. Predictors: (Constant), COLL DISC - COMPUTED

| Model | | Unstandardized Coefficients | | Standardized Coefficients | | |
|---|---|---|---|---|---|---|
| | | B | Std. Error | Beta | t | Sig. |
| 1 | (Constant) | 8.024 | .864 | | 9.283 | .000 |
| | COLL DISC - COMPUTED | .159 | .059 | .296 | 2.699 | .009** |

r = .296 , $p$ = .004

$r^2$ = .087 , $p$ = .009

Approximately 8.7% of the variance in RAS subscale #5 can be explained by COLL DISC COMP.

The regression equation is : “Not Dominated by Symptoms” = 8.024 + .159 (COLL DISC COMP)

** $p < .01$

**Recovery and Institutional Integration.** Table 6.17 shows results of a regression investigating the relationship between RAS total score and IIS total score. The two measures are strongly, positively, and significantly correlated for this survey sample.

Table 6.17

*RAS total score predicts IIS total score*

Correlations

| | | RAS - TOTAL SCORE | IIS TOTAL SCORE - COMPUTED |
|---|---|---|---|
| RAS - TOTAL SCORE (survey Q10-24) | Pearson Correlation | 1 | .540 |
| | Sig. (2-tailed) | | .000*** |
| | N | 78 | 78 |
| IIS TOTAL SCORE – COMPUTED (survey Q8-31) | Pearson Correlation | .540** | 1 |
| | Sig. (2-tailed) | .000 | |
| | N | 78 | 78 |

***. Correlation is significant at the 0.001 level (2-tailed).

Regression

Descriptive Statistics

| | Mean | Std. Deviation | N |
|---|---|---|---|
| IIS TOTAL SCORE - COMPUTED | 115.3205 | 15.16189 | 78 |
| RAS - TOTAL SCORE | 92.7692 | 15.17168 | 78 |

Model Summary[b]

| Model | R | R Square | Adjusted R Square | Std. Error of the Estimate | Change Statistics R Square Change | F Change | df1 | df2 | Sig. F Change |
|---|---|---|---|---|---|---|---|---|---|
| 1 | .540[a] | .292 | .282 | 12.84543 | .292 | 31.275 | 1 | 76 | .000** |

a. Predictors: (Constant), RAS - TOTAL SCORE
b. Dependent Variable: IIS TOTAL SCORE - COMPUTED

ANOVA[a]

| Model | | Sum of Squares | df | Mean Square | F | Sig. |
|---|---|---|---|---|---|---|
| 1 | Regression | 5160.600 | 1 | 5160.600 | 31.275 | .000[b]*** |
| | Residual | 12540.387 | 76 | 165.005 | | |
| | Total | 17700.987 | 77 | | | |

a. Dependent Variable: IIS) TOTAL SCORE - COMPUTED
b. Predictors: (Constant), RAS - TOTAL SCORE

Coefficients[a]

| Model | | Unstandardized Coefficients B | Unstandardized Coefficients Std. Error | Standardized Coefficients Beta | t | Sig. |
|---|---|---|---|---|---|---|
| 1 | (Constant) | 65.262 | 9.068 | | 7.197 | .000 |
| | RAS - TOTAL SCORE | .540 | .096 | .540 | 5.592 | .000*** |

$r = .54$, $p = .000$

Total RAS and total IIS are strongly, positively, and significantly correlated

$r^2 = .292$, $p = .000$

Total RAS accounts for approximately 29% of the variance in total IIS score. The regression equation is IIS total score = 65.262 + .540(RAS total score). If RAS total score increases by 1 point, we predict that the IIS total score will increase by approximately .540 points. If the RAS total score is 0, then IIS total score equals 65.262.

***p < .001

**Chapter Six Summary**

In this chapter, I presented quantitative results from the online survey. Frequencies and descriptive statistics were presented for relevant items. In addition, tables with correlations were presented to illustrated associations between certain variables. Paired samples t-tests were also presented to illustrate change in certain variables from high school to college, and linear regression was utilized to predict relationships among the Disclosure, Integration, and Recovery measures.

# Chapter Seven

# SYNTHESIS OF DATABASES AND DISCUSSION

## Chapter Overview

In this chapter, I first provide a side-by-side joint display of grounded themes and key related survey results (Table 7.1). I then reiterate each of the study's research questions, then merge and interpret the qualitative and quantitative findings for each question. After that, I discuss how the findings compare to related existing literature. I then offer implications for these findings and provide practice and policy recommendations.

Table 7.1 Side-by-side joint display of grounded Themes and key related Survey results

| *General Topics &* **INDUCTIVE THEMES** | **GENERAL SURVEY RESULTS RELATED TO THEMES** | **SPECIFIC SURVEY RESULTS (n=78), unless otherwise specified** |
|---|---|---|
| *Mental Health in High School* | All participants were diagnosed with at least one mood, anxiety, or psychotic disorder prior to entering college. (See Table 6.3 for details on specific diagnoses) | Across the 78 survey respondents, 183 separate MH Dx are endorsed.<br>The most common Dx are:<br>MDD (56.4% of the sample),<br>and GAD (51.3% of the sample.<br><br>In addition, 59 (75.6%) of the respondents have 2 or more Dx.<br>The mean # of Dx per participant is 2.35 |
| | Majority of respondents entered high school already having experienced a mental health problem (See Table 6.5.1) | 53 respondents (67.9%) experienced mental health problems prior to entering high school, with the remaining 25 (32.1%) first experiencing a problem during or after 9th grade. |
| | Typically, there was a lengthy delay between first experiencing disorder/symptoms and actually receiving /services. (See Table 6.5.1) | Despite 74 (94.9%) of the respondents experiencing MH problems in secondary school (and some experiencing them as early as elementary school), 26 of them (33.3%) were not diagnosed by a MH care provider until *after* completing high school.<br><br>On average, respondents had to wait 4.4 years before receiving any form of treatment. The range in period of time betw the student first noticing a problem and receiving mental health treatment is from < 1 yr to *15 yrs*. |
| | Types of MH services accessed prior to college (See Table 6.5.2) | 58 respondents (74.4%) saw a MH professional at least once prior to beginning college, while 20 (25.6%) did not receive treatment or services from any MH professionals prior to college matriculation. |
| | In high school, the majority of respondents received MH services either *both* outside of school and in school, or only *outside* of school. (See Table 6.5.2) | Of the 58 respondents who *did* seek MH services as adolescents, the majority (29, or 50%) saw both MH professionals outside of school as well as in school, while 26 (44.8%) saw only MH professionals *outside* of school. Only 3 respondents (5.2% of the 58 who sought services in HS) saw *only* a school-based MH professional. |
| | Hospitalizations and school missed in high school due to symptoms were common (See Table 6.5.3) | 18 respondents (23.1%) had at least one hospitalization during secondary school<br>14 of these 18 respondents (77.8%) missed school due to these absences.<br>Absences ranged from less than one week to over 9 weeks |
| | Use of non-medical services and MH supports in HS (See Table 6.5.3): more than one quarter of respondents used social media to gather mental health-related info. | While 57 respondents (73.1%) did not access any non-medical services, organizations, or mental health supports prior to college, 21 students (26.9%) used social media to either connect with other youth facing PDs, and/or to find information on mental health and mental illness. |

| | | |
|---|---|---|
| *High Academic achievement and engagement in High School* | HS GPA (See Table 6.4.1) | Mean = 3.75<br>Range = 2.0 to 5.0 |
| *IEPs and Knowledge of College Accommodations* | Minority of respondents had an IEP in secondary school, meaning that the majority received no special services, supports, or accommodations to support their education and learning<br>(See Table 6.1; Figure 6.3.2)<br><br>There is a sig. diff. in the number of respondents who had IEPs in HS and the number who accessed accommodations through SDS in college, with significantly more students accessing accommodations in college (see Table 6.6 and Figure 6.3.2). | 12 respondents (15.4%) had an IEP in HS, while 66 (84.6%) did not. This could partially explain why so few of the respondents were aware of IDEA (7, 9.0%), the ADA (17, 21.8%), or Section 504 of the Rehabilitation Act (4, 5.1%) when applying to college (see Figure 6.2.5), and how this civil rights legislation could be used to access educational supports and academic accommodations at SDS.<br><br>30 survey respondents (40%) accessed academic accommodations in college (see Figure 6.3.1) |
| *Work, Volunteering, and Extra-curriculars* | In high school, the majority of respondents were engaged in their schools and – at least to a degree – integrated into their communities. (See Tables 6.4.1 and 6.4.2) | 43 respondents (55% of the sample) had a paid job while in HS, 57 (73%) did some form of volunteer work, and 72 (92%) participated on some sort of extracurricular activity at school, with sports listed as the most common activity. Also note that among the respondents who worked for pay in HS, 29 (37%) worked between 11 and 30 hrs/week. |
| *Social Life* | Social Life in College is perceived as better than social life in high school. (See Table 6.4.3 for statistics and visual representations in Figures 6.1.1 and 6.1.2) | Reports of having "at least one good, trusted friend to talk to" and being "satisfied" with one's social life were significantly higher in college than in high school. |
| **SECRETS & SILENCES** | Regarding overall level of mental health disclosure in high school: the majority of respondents told at least one person at school about their mental illness. (See Tables 6.8.1, 6.8.2, and 6.8.3)<br><br>If HS students disclose, they are more likely to tell a peer than an adult at school | 58 respondents (74.4%) disclosed to at least one adult staff member *or* to a peer at their high school.<br><br>Of the 58 "disclosers," 57 (98.3% of disclosers) disclosed to peers, while only 37 (63.8% of disclosers) shared an aspect of their MI with a school staff member. On average, high school students are 1.5 times more likely to make a mental health disclosure to a peer at school than they are to a school staff person. |
| | Mental health disclosures increase in college (See Table 6.8.2 and Figure 6.4.1) | HS DISC-COMPUTED mean score is 7.96, while the<br>COLL DISC-COMPUTED mean score is 13.4<br>(both have a possible "high" score of 30 and a "low" score of 1)<br>The difference between these scores is statistically significant. |

| | | |
|---|---|---|
| | Some students did not tell anyone at all about their PDs, either in HS or College (See Table 6.8.3 and Figure 6.5) | 20 respondents (25.6%) disclosed to no one at all while they were in HS, and 15 (19%) did not disclose to anyone in college. |
| **IT'LL BE BETTER IN COLLEGE** | The majority of respondents had high expectations for going to college (See Figures 6.2.1 and 6.2.2) | Survey response to statement "I always knew that I would go to college," answered on a Likert scale from [5] Strongly Agree, to [1] Strongly Disagree, mean (n=78) is 4.37.<br>SD = 1.05<br><br>68 respondents (87.2%) endorsed the above statement by answering "Strongly Agree" or "Agree" |
| | The majority of respondents thought about college a lot and put a great deal of effort into planning for college (See Figures 6.2.1 and 6.2.2) | 64 respondents (87.2%) endorsed the statement "I spent a lot of time thinking about college," and 57 (73.1%) endorsed the statement "I put a lot of effort into planning for college." |
| | Despite the above, however, the majority of respondents did not consider their mental illness in relation to preparing for, selecting, or applying to college. (See Figures 6.2.1 and 6.2.4) | A small majority of respondents, 40 (51.3%), endorsed the statement "When thinking about whether to attend college, I considered my MI and how it might influence my experience."<br><br>However, only 27 (34.6%) endorsed "when thinking about to which colleges I should apply, I considered my MI"; only 15 (19.2%) endorsed "when researching colleges, I investigated what types of services and support certain schools have for students with MI"; only 6 (7.7%) reported actually contacting certain colleges to ask about their services and supports for students with MI; and only 2 respondents (2.6%) applied to certain colleges based on the services and support they offer to students with MI. |
| **I CAN DO IT ON MY OWN** | The majority of students considered a college's geographic location. (See Figure 6.2.6) | 66 (84.6%) respondents reported considering a college's geographic location when deciding where to apply and attend. |
| *Moving away from home* | Respondents reported various reasons for considering a college's geographic location. (See Figure 6.2.6) | 33 respondents (50% of the 66 who considered college location) reported that they "wanted to be independent from parents/caregivers and live on [their] own."<br><br>20 respondents (43.9%) endorsed the statement "I wanted to be close enough to parents to drive home if I needed a break form school."<br><br>And 16 (24.2%) endorsed the statement "I wanted to start over in a new place where no one knew about my MI." (Note that five other less common reasons for considering a college's location are presented in Figure 6.2.6.) |

| | | |
|---|---|---|
| *Use of MH services in college* | Majority of respondents have seen at least one MH professional since beginning college. (See Table 6.7.1) | 73 respondents (93%) have seen at least one MH professional since beginning college. |
| | Majority of respondents saw on-campus MH professionals while in college, and the second largest group saw both on- and off-campus MH professionals. (See Table 6.7.1) | 50 of the 73 students (93.6%) who saw a MH professional in college accessed services at their campus Counseling and Psychological Services Center.<br><br>30 (41.2% of the 73 who accessed MH services in college) saw *both* on-campus and off-campus MH professionals.<br><br>22 (30.1%) saw only off-campus MH professionals<br><br>And 20 (27.4%) saw only on-campus providers |
| | Nearly the same number of students were hospitalized and missed school in college as were hospitalized and missed school in High School (See Table 6.7.2) | 17 (21.8%) respondents were hospitalized during college (and 18 were hospitalized at some point during secondary school). This means that > 1/5 of the sample experienced a hospitalization in college.<br><br>14 of these 17 students missed college classes due to their hospitalizations, and these absences ranged from < 1 week to 3 years<br><br>The length of hospitalizations in college ranges d from < 1 week to 8 weeks (See Table 6.7.2) |
| | More students utilize non-medical services and MH supports in college than in high school (Compare Table 6.7.3 with Table 6.5.3) | Although only 21 students (26.9%) accessed MH-related websites or participated in MH clubs or organizations in HS, 64 students (82.1%) do so once in college. |
| **THERE'S SOMETHING YOU SHOULD KNOW** | Overall level of disclosure in COLL.<br>*This level is higher than the average overall level of disc in HS<br><br>(See Tables 6.8.1 and 6.8.2, and Figures 6.4.1 and 6.4.2) | COLL DISC – COMPUTED mean score = 13.76 (SD is 6.10)<br>*Note that the HS DISC-COMPUTED mean was 7.96 (SD was 6.00)<br><br>Possible "High" score of 31<br>Range = 30<br>Min = 1<br>Max = 31 |
| *Disclosing to Peers* | Majority of students disclosed to at least one peer when in HS. (See Table 6.8.3) | 58 students disclosed to at least one peer or adult at school when they were in High School.<br>57 of these students (98.3%) disclosed to at least one peer in HS, meaning that only 1 student disclosed solely to an adult staffer at school. |

| | | |
|---|---|---|
| | More students disclose to "certain friends at school" in college than they do in HS (See Tables 6.8.4 and 6.9.1) | The difference between disclosures to "certain friends" in High School and College is statistically significant ($t_{56} = 5.01$, $p = .000$) |
| | Reasons to disclose to HS peers are related to both *identity/emotional* and *relational* reasons, while reasons to disclose to college peers are primarily *relational.* (See Table 6.10.1, as well as Figure 6.6.1 and 6.6.2) | Reasons for disclosing to peers change over time<br><br>The two most common reported reasons to disclose to peers in high school (equal # of responses) are (1) "so people could support me if I needed help managing my mental illness" and (2) "because it was a relief to not keep it a secret."<br><br>In contrast, the two most common reported reasons to disclose to peers in college are (1) "so peers could understand me better" and (2) "in order to share details about my life and deepen friendships" |
| | The reasons given *to* disclose and *not* to disclose change between HS and college.<br><br>(See Tables 6.8.6 and 6.10.1, and Figures 6.6.1, 6.6.2, and 6.15 for reasons *to* disclose; see Tables 6.14 and 6.15, and Figures 6.9.1 and 6.9.2 for reasons *not* to disclose). | The most common reason endorsed for disclosing to peers in HS is a tie between "because it was a relief to not keep it a secret" and "so people could support me if I needed help managing my MI."<br><br>The most common reason endorsed for disclosing to peers in College is: "so peers can understand me better"<br><br>The most common reason endorsed for *not* disclosing in HS is: "I was afraid people would think less of me"<br>The most common reason endorsed for *not* disclosing in College is: "I don't want any special treatment" |
| | Survey respondents' perceptions of peer reactions to their disclosures change over time.<br><br>On average, peer responses are believed to improve over time from HS to college. (See Figures 6.7.1 and 6.7.2, and Table 6.11.3) | There are significant differences between HS and COLL<br><br>The most common perception of peer reaction to a disclosure in HS is: "treated me the same afterwards"<br><br>The most common perception of peer reaction to a disclosure in College is: "Listened respectfully" |
| *Disclosing to School or College Faculty & Staff* | HS teachers and other school staff (not mental health professionals) are *more* likely to receive a MH disclosure from a HS student than are secondary school counselors, social workers, and psychologists. (See Table 6.8.3) | Of the 58 "disclosers," 37 (64%) told an adult at their high school. And of these adult recipients, 32 (55% of the 58) were teachers or other non-mental health staff, while 26 (45% of the 58) were school counselors, social workers, or psychologists. |

| | | |
|---|---|---|
| | The reasons given for disclosing to HS teachers and college faculty are primarily academic, as opposed to relational (See Figures 6.4.5 and 6.4.6) | Note, also, that of the 37 students who disclosed to HS teachers, 24 (65%) said they did so "only when it was so obvious that [they] could no longer hide it" (See Table 6.8.6 and Figure 6.4.5). In college, 41 total students disclosed to at least one faculty or campus staff person (see Figure 6.4.3), and 21 (51%) of them endorsed the "only when I could no longer hide it" statement (see Figure 6.4.5). |
| | The reasons given for disclosing to faculty and school staff change over time<br>(See Tables 6.8.6 ad 6.8.8, as well as Figures 6.4.5 and 6.4.6) | The most common reason endorsed for disclosing to HS teachers and staff is: "Only when it was so obvious that I could no longer hide it."<br><br>But the most common reasons endorsed for disclosing to College faculty and staff are (tied): "To access formal services and academic accommodations" and "To get help with assignments if I had to miss class because of my MI" |
| | Survey respondents' perceptions of Faculty/Staff reactions to their disclosures change over time.<br><br>On average, they feel that responses to their disclosures from teachers and faculty improve over time. (See Figures 6.4.7, 6.4.8, 6.4.9, and 6.4.10, as well as Tables 6.8.13, 6.8.14, and 6.8.15) | Three reactions "accepted me," "seemed uncomfortable," and "treated me better afterwards") have means that are significantly different in HS than college.<br><br>Students feel more "accepted" by college faculty after disclosing some aspect of their MI; HS teachers and staff seemed more "uncomfortable" after receiving MH disclosures and HS teachers and staff treated students "better" after a disclosure than did college faculty. (This may be because college faculty were *already* treating students relatively well, while HS staff had more room for improvement.) |
| *Comparing Disclosures to Peers with Disclosures to School or College Faculty & Staff* | At both the HS and College level, far more disclosures are made to peers for "relational" reasons than are made to faculty or staff for "relational" *or* "academic" reasons. (This distinction is even greater in college than in HS, as over-all level of DISC goes up)<br>(See Figures 6.4.6 and 6.6.2) | A total of 23 endorsements for "relational" reasons for disclosing to HS teachers or staff were given, with 43 endorsements for "academic" reasons.<br><br>A total of 32 endorsements for "relational" reasons for disclosing to college faculty or staff were given, with 50 endorsements for "academic" reasons.<br><br>In contrast to the above, a total of 115 endorsements for "relational" reasons for disclosing to peers in HS were given, with only 5 "academic" reasons endorsed.<br><br>And 257 endorsements for "relational" reasons for disclosing to peers in College were given, with only 20 endorsements for "academic" reasons. |
| | More students disclosed to "one trusted teacher at school" in HS than they did in College (See Table 6.8.5 and Figure 6.4.4) | The difference between disclosures to "one trusted teacher" in High School and College is statistically significant ($t_{22} = 2.79$, $p = .011$), with disclosures to one trusted teacher in HS more common. |

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| *Disclosing in College Application Essays* | Some students w/ PDs make MH disclosures in their college application essays.<br>(See Table 6.13 and Figure 6.8) | 23 study participants made MH disclosures in their college application essays (29.5% of the entire sample). Among these "college essay disclosers," 20 (87.0%) chose to do this "to show the admissions committee that [they] have overcome a lot of challenges," while 19 (82.6%) said it was "because it is an important part of [them]," and 18 (78.3%) disclosed in their college essays "because it made [them] different from the typical applicant." These are the top three reasons given.<br><br>Interesting, the fourth most common reason given (endorsed by 15 participants, or 65.2% of the college essay disclosers) was "to support my interest in psychology, or some other mental health-related academic discipline." |
| *Disclosure and Institutional Integration total score* | Disclosure in college is significantly positively correlated with Institutional Integration (total score).<br>(See Table 6.15.2) | COLL DISC – COMPUTED is significantly positive correlated with IIS TOTAL SCORE<br>r = .327 (a "weak" to "moderate" correlation)<br>$r^2$ = .107<br>*p* = .003<br>The correlation is significant at the 0.00 level (2-tailed).<br>Approx. 11% of the variance in total IIS score can be accounted for by the COLL-DISC COMPUTED score. |
| *Disclosure and Institutional Integration sub-scale scores* | Disclosure in college has a positive and significant assoc. w/ IIS subscale #1 "Peer Grp Interactions" (see Table 6.15.3) and subscale #2, "Interactions with Faculty" (see Table 6.15.4). | COLL DISC – COMPUTED is significantly positively correlated with IIS subscale #1, "Peer Grp Interactions"<br>r = .425 (a "moderate" correlation)<br>$r^2$ = .181<br>*p* = .000<br>The correlation is significant at the 0.01 level (2-tailed).<br>Approx. 18% of the variance in IIS sub-scale #1, "Peer Group Interactions," can be explained by the COLL-DISC COMPUTED score.<br><br>Mean score on IIS subscale #1 = 25.1 (see Table 6.15.1 and Figure 6.10)<br>SD = 5.91<br>Possible "High" subscale score on subscale #1 = 35<br>Range = 25<br>Min= 10<br>Max= 35 |

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| | Disclosure in college has a positive and significant assoc. w/ IIS subscale #2, "Interactions with Faculty" (see Table 6.15.4). | COLL DISC – COMPUTED is significantly positively correlated with IIS subscale #2, "Interactions w/ Faculty"<br>r = .406 (a "moderate" correlation)<br>$r^2$ = .165<br>*p* = .000<br>The correlation is significant at the 0.01 level (2-tailed).<br>Approx. 16.5% of the variance in IIS sub-scale #2, "Interactions w. Faculty" can be explained by the COLL DISC COMP score.<br><br>Mean score on IIS subscale #2 = 18.5 (see Table 6.15.1 and Figure 6.10)<br>SD = 3.96<br>Possible "High" subscale score = 25<br>Range = 14<br>Min = 11<br>Max = 25 |
| | IIS sub-scales #3 thru #5 are not associated with COLL DISC-COMPUTED. | |
| *Disclosure and Help-seeking* | Disclosure to college peers is *not* associated with use of campus Student Disability Services (SDS). | See Table 6.12.3 |
| | Disclosure to college peers *is* positively and significant correlated with use of Counseling & Psychological Services (CAPS) on campus. (See Table 6.12.4) | A regression shows that mental health disclosures to college peers is positively, moderately, and significantly correlated (r = .390, $r^2$ = .152), and approximately 15% of the variance in the use of CAPS can be explained by Disclosure to College Peers. The p-value for the regression model is *p* = .001, indicating that the model is a good fit for the data. |
| *Disclosure and Recovery Assessment Scale (RAS) total score* | COLL DISC COMPUTED score predicts RAS total score (see Table 6.16.2). | COLL DISC COMP and RAS total scores are positively, moderately, and significantly correlated.<br>r = .387<br>$r^2$ = .150<br>*p* = .000<br>Approximately 15% of the variance in RAS total score can be explained by COL1 DISC COMP score. |

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| *Disclosure and Recovery Assessment Scale (RAS) sub-scale scores* | COLL DISC COMPUTED score predicts RAS subscale #1, "Personal Confidence & Hope" (See Table 6.16.3) | Subscale #1 on RAS, "Personal Confidence & Hope," has a positive and sig. correlation w/ COLL DISC-COMPUTED score.<br><br>r = .384<br>$r^2$ = .147<br>*p* = .001<br>The correlation is significant at the 0.01 level (2-tailed).<br>Approximately 15% of the variance in one is explained by the other.<br><br>Mean RAS subscale #1 score = 33.2 (see Table 6.16.1 and Figure 6.11.1)<br>SD = 7.0<br>Possible "High" score of X on subscale #1 = 45<br>Range = 33<br>Min = 12<br>Max = 45 |
| | COLL DISC COMPUTED score predicts RAS subscale #2 "Willingness to Ask for Help" (see Table 6.16.4) | Subscale #2 on RAS, "Willingness to ask for help," has a positive and sig. correlation w/ COLL DISC-COMPUTED score.<br>r = .234 (weak correlation)<br>*p* = .039<br>$r^2$ = .055<br>The correlation is significant at the 0.05 level (2-tailed).<br>Approx. 5.5% of the variance in one is explained by the other.<br><br>Mean RAS subscale #2 score = 11.40 (See Table 6.16.1 and Figure 6.11.1)<br>SD = 2.96<br>Possible "High" score of 15 on subscale #2 = 15<br>Range = 14<br>Min = 4<br>Max = 18 |
| | COLL DISC COMPUTED score predicts RAS subscale #3 "Goal & Success Orientation" (see Table 6.16.5) | Subscale #3 on RAS, "Goal & Success Orientation," has a positive and sig. correlation w/ COLL DISC-COMPUTED score.<br>r = .249<br>*p* = .014<br>$r^2$ = .062<br>The correlation is significant at the 0.05 level (2-tailed).<br>Approx. 6.2% of the variance in one is explained by the other.<br><br>Mean RAS subscale #3 score = 21.46 (see Table 6.16.1 and Figure 6.11.1) |

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| | | SD = 3.29<br>Possible "High" score of X on subscale #3 = 25<br>Range = 13<br>Min = 12<br>Max = 25 |
| | COLL DISC COMPUTED score predicts RAS subscale #4 "Reliance on Others" (see Table 6.16.6) | Subscale #4 on RAS, "Goal & Success Orientation," has a positive and sig. correlation w/ COLL DISC-COMPUTED score.<br>r = .285<br>*p* = .006<br>$r^2$ = .081<br>The correlation is significant at the 0.01 level (2-tailed).<br>Approx. 8.1% of the variance in one is explained by the other.<br><br>Mean RAS subscale #4 score = 16.6 (see Table 6.16.1 and Figure 6.11.1)<br>SD = 2.51<br>Possible "High" score of X on subscale #4 = 20<br>Range = 9<br>Min = 11<br>Max = 20 |
| | COLL DISC COMPUTED score predicts RAS subscale #5 "Not Dominated by Symptoms" (see Table 6.16.7) | Subscale #5 on RAS, "Goal & Success Orientation," has a positive and sig. correlation w/ COLL DISC-COMPUTED score.<br>r = .296<br>*p* = .004<br>$r^2$ = .087<br>The correlation is significant at the 0.01 level (2-tailed).<br>Approx. 9% of the variance in one is explained by the other.<br><br>Mean RAS subscale #5 score = 10.2<br>SD = 3.14<br>Possible "High" score of X on subscale #5 = 15<br>Range = 12<br>Min = 3<br>Max = 15 |
| **DISABILITY? *ME*?!** | Very few participants had IEPs or any academic accommodations in HS<br>(See Table 6.1) | 12 survey respondents (15.4%) had IEPs in High School. |

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| | The majority of respondents did not know of, or learn about, academic accommodations at the colleges to which they applied. (See Figure 6.2.5) | Only 14 study participants (17.9%) endorsed the statement "I knew how students with mental illness could access academic accommodations at the colleges where I applied."<br><br>And only 18 participants (23.1%) endorsed the statement, " I knew of services and supports available to students with disabilities at the colleges where I applied." |
| | The majority of respondents did not know about federal legislation protecting the rights of students with disabilities when they entered college. (See Figure 6.2.5) | 17 participants (21.8%) were aware of ADA and what it means for college students with disabilities.<br><br>4 (5.1%) were aware of Section 504f the Rehabilitation Act, and what it means for college students with disabilities.<br><br>And 7 study participants (9.0%) were aware of IDEA and what it means for children and youth with disabilities and their education. |
| | The majority of respondents received some assistance with college applications from parents or caregivers (See Figure 6.2.3) | 72 study participants (92.3%0 reported receiving some "assistance and support" from parents or caregivers when applying to college. |
| | Fewer than half of the study participants accessed academic accommodations through Student Disability Services in college. (See Figure 6.3.1) | Only 31 study participants (40% of the total sample) accessed any academic accommodations during college. This means that 60% of study participants did not use any accommodations in college.<br><br>Also, although only 31 (40%) used academic accomms. in college, this is a significant increase from the 12 (15.4%) participants who had IEPs and acad. accomms. In HS |
| | "Willingness to ask for help" subscale on RAS is not associated w/ actually accessing SDS.<br><br>*Note, however, that Disclosure to college peers *is* positively correlated with use of CAPS on campus. (See Table 6.12.4, below). | RAS subscale #2, "Willingness to ask for Help" is *not* associated with disclosing at SDS in order to access academic accommodations.<br><br>r = .027<br>*p* = .824 *No significant correlation<br>$r^2$ =.001<br><br>Why might this be?<br>Perhaps college students w/ PDs do not think that SDS services are "for them" (re: they don't qualify because they don't have physical disabilities). Is this the case? No – only 2 study participants (2.6%) endorsed this reason for not accessing academic accommodations at SDS. |

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| | | Or, perhaps being "willing to ask for help" is associated only with disclosures to peers, and not to college staff. Is this the case? No – it turns out that "Willingness to ask for help is not significantly correlated w/ Disclosure to peers in college (Q9-13).<br><br>"Willingness to ask for Help" is also not associated w/ disclosing to college faculty or staff. |
| *Reasons for accessing accommodations in college* | For students who *do* access accommodations in college, why do they do this?<br>(See Figure 6.3.3) | The most common reason given for requesting accommodations in college is the following (given by 7 of the 31 survey respondents, or 23%, who did request accommodations): "Because they help me to succeed academically." |
| *Accommodations used* | And what accommodations do they use?<br>(See Figure 6.3.4) | The most frequently requested academic accommodation in college (requested by 16 of the 31 (52%) survey respondents who utilized accommodations) was "extra time on tests and/or assignments." |
| *Reasons to **not** access accommodations in college* | And for students who do *not* access accommodations, why not?<br>(see Figure 6.3.5) | The most common reason given for not using academic accommodations in college is "I don't need them." 23 of the 47 survey respondents (49%) who did not access accommodations endorsed this reason. |
| **RELATING FOR RECOVERY; SAFE SPACES** | (Note that this theme is related to HS and COLL disclosures to peers, above.) | |
| *Friends and Satisfaction with Social Life* | The majority of students w/ PDs have at least one good, trusted friend in college.<br><br>In addition, over (55%) half of them report that they are "satisfied" with their social lives in college (a higher level than were satisfied w/ their social lives in HS). This means, however, that 45% of students are not satisfied socially. | 43 respondents (55.1%) endorsed the following statement:<br>"I am satisfied with my social life in college."<br><br>64 respondents (82.1%) endorsed the following statement:<br>"In college, I have at least one good friend that I trust and can talk to if I need support." |
| *Peer Group Interactions and Disclosure* | Peer Grp Interactions, sub-scale #1 on IIS is sig. and positively correlated with COLL DISC – COMPUTED (see Table 6.15.3). | IIS subscale #1, "Peer Grp Interactions" is significantly positively correlated with COLL DISC – COMPUTED<br>$r = .425$ (a "moderate" correlation)<br>$r^2 = .181$<br>$p = .000$<br>The correlation is significant at the 0.01 level (2-tailed).<br>Approx. 18% of the variance in IIS sub-scale #1, "Peer Group Interactions," can be explained by the COLL-DISC COMPUTED score. |

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| | | Mean score on IIS subscale #1 = 25.1 (see Table 6.15.1 and Figure 6.10)<br>SD = 5.91<br>Possible "High" subscale score on subscale #1 = 35<br>Range = 25<br>Min= 10<br>Max= 35 |
| *Faculty Interactions and Disclosure* | Faculty Interactions, sub-scale #2 on IIS is sig. and positively correlated with COLL DISC-COMPUTED (see Table 6.15.4). | IIS subscale #2, "Faculty Interactions" is significantly positively correlated with COLL DISC – COMPUTED<br><br>r = .406 (a "moderate" correlation)<br>$r^2$ = .165<br>*p* = .000<br>The correlation is significant at the 0.01 level (2-tailed).<br>Approx. 16.5% of the variance in IIS sub-scale #2, "Interactions w. Faculty" can be explained by the COLL DISC COMP score.<br><br>Mean score on IIS subscale #2 = 18.5 (see Table 6.15.1 and Figure 6.10)<br>SD = 3.96<br>Possible "High" subscale score = 25<br>Range = 14<br>Min = 11<br>Max = 25 |
| | Half of students have joined a campus-based MH awareness or advocacy club at some point during college. | 39 students (50.0% 0f entire sample) has been a member of a campus-based MH awareness or advocacy club at some point during college. And 32 students (41.0%) were current members at the time of the survey.<br><br>*Note that this fairly high percentage for MH club membership may not be generalizable because one of the avenues for recruitment of survey participants was contacting campus-based MH clubs and asking them to disseminate the online survey link. |
| **TIME OUT OF SCHOOL** | Time out of school due to MH in HS<br>**(See Table 6.5.3)** | 18 of the survey respondents (23%) had at least one hospitalization in middle or high school, and for 14 of these students, their hospital stays caused school absences.<br><br>Absences related to treatment ranged from less than 1 week to more than 9 weeks. |

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| | Time out of school due to MH in COLL **(See 6.7.2)** | 17 of the survey respondents (22%) had at least one hospitalization during college, and for 14 of these students, their hospital stays caused college absences.<br><br>Absences related to treatment or symptoms ranged from less than 1 week, to 3 years. |
| | Transferring among multiple colleges | *There was no item on the survey that asked about transfer among colleges. However, among all of the *interview* participants, 9 of the 26 (34.6%) attended 2 or more institutions of higher education; this rate is actually lower than the national average for college student transfer, which is currently estimated to be 37.2% (Nat'l Student Clearinghouse Research Center, 2015.) |
| **FINDING PURPOSE (RECOVERY)** | RAS total score | **RAS Total score, mean = 92.77**<br>SD = 15.17<br><br>Possible "High" score of 120<br>Range = 71<br>Min = 49<br>Max = 120 |
| | RAS subscale #3: "Goal & Success" Orientation" is positively and significantly correlated with COLL DISC-COMPUTED scores. | RAS subscale #3 mean score = 21.46<br>SD = 3.29<br><br>r = .25 (a "weak" correlation)<br>*p* = .027<br>The correlation is significant at the .05 level (2-tailed)<br>$r^2$ = .063<br>6.3% of the variance in one is explained by the other<br><br>Possible "High" score of 25 for this subscale (See Table 6.16.1)<br>Range = 13<br>Min = 12<br>Max = 25 |
| | # of participants pursuing a "helping profession" based on their choice of college Major | Of the 73 respondents (93.6%) who had declared a college major, 33 (42.3%) had chosen majors in Psychology (by far the most common Major), Neuroscience, Brain/Cognitive Science, Social Work, Nursing, Counseling, or another pre-helping or MH-related professions |
| | Majority of respondents aspire to graduate school | 61 respondents (78.2%). aspire to completing a graduate or professional degree after college. |

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| **THE (PATIENT) STUDENT** | High HS academic achievement among survey respondents. Average cumulative HS GPA among survey respondents is 3.75, while the national average is 3.0 (Nat'l Center for Education Statistics, 2011) | mean HS GPA = 3.75 |
| | National average cumulative GPA college in 2013 was 3.15 (See www.gradeinflation.com) | mean COLL GPA = 3.36 |
| | The majority of survey respondents attend 4-year colleges or universities, and many of them attend selective or highly selective schools<br>(See Table 6.1) | 75 respondents (96.2%) attend 4-yr institutions, and 3 (3.8%0 attend 2-yr institutions. 32 respondents (41.0%) attend public research universities; 24 (30.8%) attend private research universities; 15 (19.2%) attend private liberal arts colleges; 4 (5.1%) attend public regional colleges; and the remaining 3 are the students attending community colleges.<br><br>14 respondents (17.9%) are attending some of the most highly selective schools in the nation (including MIT, Columbia, Penn, Brown, Johns Hopkins, UC Berkeley, Swarthmore, and Haverford) |
| | Majority of respondents attend college full-time<br>(See Table 6.1) | Only 1 respondent (1.3%) attends college as a part-time student; the remaining 77 survey respondents attend college full-time. |
| **LEARNING TO LIVE** | MH service use in college<br>(See Table 6.7.1) | The majority (73, or 94%) of respondents sought MH services while in college. 50 of these 73 students (68.5%) accessed services at their campus' CAPS center at some point. 30 of these students (41%) accessed services *both* on and off-campus, 22 (30%) saw *only* off-campus MH providers, and 20 (27%) saw only on-campus providers. That said, the majority of respondents do not solely use CAPS on campus. |
| | Non-medical services and supports accessed in college (See Table 6.7.3)<br>• Campus-based MH clubs<br>• Social media sites related to MH, Wellness, and Recovery<br>• Supported Education (only 2 students) | 64 survey respondents (82%0 accessed non-medical services, organizations, or other MH support while in college. 35 respondents (45% of the total sample) were members of a cam pus Active Minds chapter, 20 (36%) accessed social media sites related to MH, and 15 each (19%) accessed NAMI on Campus or "other" services. Only 2 respondents (2.6% of the total sample) participated in a "Supported Education" program for college students with mental illness. |
| | IIS total score<br>(See Table 6.15.1) | **Mean = 115.32**<br>SD = 15.16<br>Possible "High" score = 150<br>Range = 68<br>Min = 77<br>Max = 145 |

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| | RAS total score<br>(See Table 6.16.1) | **Mean = 92.77**<br>SD = 15.17<br>Possible "High" score = 120(?)<br>Range = 71<br>Min = 49<br>Max = 120 |
| | RAS total score predicts IIS total score (see Table 6.17 | The two measures are strongly, positively, and significantly correlated for this survey sample. |

**RQ #1 What is the process of preparation for and transition to and through higher education for emerging adults (EAs) with psychiatric disabilities (PDs)?**

**1.a. How do adolescent high school students with PDs prepare for college?**

Themes emerging from the qualitative analysis lend support to students being prepared for college in terms of motivation to go and enthusiasm and optimism about the potential experience (IT'LL BE BETTER IN COLLEGE). However, the majority of these same students shared that they did not disclose their mental health challenges to peers or school staff in high school (SECRETS & SILENCES), that they did not have IEPs or receive special education services and supports in high school, and that they did not know of their rights under IDEA and the ADA (DISABILITY? *ME*?!).

The quantitative results are in line with the qualitative findings. The majority of survey respondents experienced mental health challenges and symptoms in high school (77; 98.7%), but most (41; 52.6%) did not disclose to staff in high school, nor did they seek academic services or supports. Eighteen respondents (23.1%) experienced hospitalizations or residential treatment while in high school, and the majority of this subsample (14; 77.8%) experienced school absences due to this treatment. Despite these challenges, however, the majority of the students did well academically in high school (with a mean GPA of 3.75 out of 4.0), with 75 (96.2%) matriculating into four-year colleges and the remaining 3 entering two-year colleges.

However, survey respondents also reported that they did not, on average, consider their mental health or psychiatric disabilities when selecting or applying to colleges. Only 18 respondents (23.1%) knew of services and supports available to students with disabilities at the colleges to which they applied, and only 14 (17.9%) knew how students with mental illnesses might access academic accommodations at these colleges.

**College "readiness" for rehabilitation**. Although current college "readiness" literature primarily focuses on academic factors associated with success in one's first year (Conley, 2011), with additional emphasis on "college knowledge" and skills related to applying to and navigating higher education (Conley, 2011), the results of the current study demand an expanded understanding of college "readiness" for the large number of adolescents and emerging adults with psychiatric disabilities who aspire to college. As is noted earlier in this manuscript, high school students with emotional-behavioral disorders have the highest rates of under-achievement and school dropout among all disability groups (Newman et al., 2011); and for the small minority of these youth who *do* graduate and go on to college, they remain the most likely to withdraw without completing a degree (Egyed, McIntosh & Bull, 1998; Nolan, 2011). If we are to address these disparities and send more young people to college ready to learn and thrive there, then commonly held conceptions of "college readiness" are in need of critique, revision, and expansion.

Students who are identified with disabilities in K-12 are eligible to receive services and supports such as Individual Education Plans (IEPs); among other accommodations, IEPs include mandated "transition planning" meetings in which adolescent students engage in conversations with Special Educators and counselors related to post-secondary goals and plans. Though transition planning is federally mandated for youth with disabilities (U.S. Department of Education, 2000), many students diagnosed with emotional behavioral disorders are, in fact, not identified by their schools as having disabilities - and without identification, protections offered through the Individuals with Disabilities Education Act are not provided (IDEA, 2004).

Students with "internalizing" emotional behavioral disorders (EBD) such as anxiety and depression, in particular, are less likely to be identified as needing services than peers who present with "externalizing" (and more visible) challenges such as oppositional defiant disorder (APA, 2013). A student with a more "invisible disability" (Rehfuss & Quillin, 2005; Wolf, 2001) such as depression, for example, is more likely to be overlooked, and may never receive post graduation transition services at school, even if she or he has a diagnosis from a mental health professional. It is these students in particular who may need the most assistance in terms of college and career readiness, and instituting practices at both the secondary school and higher education levels to support such students in their college selection and application processes may be highly beneficial. (See Figures 7.3.1 and 7.3.2 on pages 373 and 374 of this chapter for detailed recommendations on rehabilitating "readiness" for college and "transitions" to college at both the individual and institutional levels.)

Instead of college readiness, a better term might be "life readiness." Rather than just academic preparedness, students must consider other aspects of leaving high school and moving on to higher education. This includes the practical steps necessary to matriculate into college such as placement tests, financial aid, time management, and forming new social networks. And for high school students with psychiatric disabilities in particular, interventions that promote self-advocacy and thinking strategically through what (if any) counseling and psychological services various colleges offer, and whether or how to disclose one's disability on campus, may be associated with better academic achievement as well as greater over-all institutional integration. Testing the effectiveness of such interventions remains to be seen in future research.

**1.b. What are these students' experiences of social and academic integration in college over time?**

**Academic Integration.** Despite having dealt with mental health symptoms in high school, the interview participants reported *high hopes for college* and anticipation of *a new, fresh start*. The majority of them also expressed the themes I CAN DO IT ON MY OWN and I HAVE A DISABILITY? *ME*?! These two themes are related in that the autonomy and self-determination expressed in the former (and common in emerging adulthood) led some interviewees to refuse the label "disabled," and/or to forego seeking mental health or Student Disability Services once in college. Academically, the majority of the interviewees struggled at some point in college due to a relapse or recurrence of their symptoms, and seven (26.9% of the 26 interviewees) took psychiatric medical leaves (TIME OUT OF SCHOOL). It may be that had these students disclosed to either a mental health professional on campus, and/or to a staff member at the student disability services center, they may have received services and supports that could have prevented academic struggles, course failures, or even their medical leaves.

***Mental health help-seeking.*** Instead of seeking help as a precautionary or "prevention" strategy, the interviewees described only reaching out for help from campus staff in the face of a crisis or imminent course failure. This finding aligns with existing literature, which shows reluctance among students with mental health concerns to seek help (McAuliffe et al., 2012, p. 120). In one large survey of college students in the U.S., 67% perceived a need for mental health services, but only 38% sought such services during the previous year (Cranford, Eisenberg, & Serras (2009). In another recent survey implemented by the National Alliance on Mental Illness (Gruttadaro & Crudo, 2012), more that 45% of young adults who stopped attending college because of mental health-

related reasons did not request academic accommodations before leaving school, and 50% did not access any mental health services or supports on campus before dropping out, either. In the longitudinal Healthy Minds Study of over 13,000 college students from 26 U.S. institutions (Hunt & Eisenberg, 2010), 40% of respondents with diagnosable mental health conditions did not seek help, and 57% did not request accommodations from their schools.

Taken together, the above evidence supports the claim that young adults' mental health concerns are often greater than their actual help-seeking and service use. However, as McAuliffe et al. (2012) point out, "it is unknown whether students fail to engage in help-seeking behaviors due to their own reluctance or fear, which may be associated with real or perceived stigma, or due to a lack of available or suitable mental health services, or both" (p. 120). Eisenberg, Speer, and Hunt (2012) of the Healthy Minds Study, however, found that among students meeting criteria for a mental health diagnosis, 65% reported low stigma and held positive beliefs about treatment effectiveness. This finding points to the possibility that "for a large proportion of young people with untreated mental illness, attitudes and knowledge about mental illness may no longer be among the main barriers to help seeking" (Eisenberg, Speer, & Hunt, 2012, p. 711).

The finding that stigma may not be the primary reason for avoidance of help-seeking among contemporary college students buttresses the current study's qualitative finding that college students desire autonomy and self-determination, and that these pillars of typical emerging adult development (Arnett, 2000), may, in fact, have more to do with refraining from help-seeking than internalized or perceived public stigma. In

addition, Laidlaw et al. (2015) write that "undergraduate students are most likely to seek help for mental well-being difficulties from peers," as opposed to from campus staff. This earlier finding is supported by the current study's findings, and it may be that because most previous studies focus on formal help-seeking from campus staff, informal help-seeking from peers is overlooked.

In the current study, more respondents (63; 80.8%) disclosed to college peers than solely to campus staff (2; 2.6%). This likely means that students are turning to their peers for help (necessitating disclosure) instead of, or in addition to, college faculty and staff. A large majority of survey respondents, however, (73; 93.6%) did see at least one mental health professional since beginning college (either on- or off-campus), and 50 of these 73 students (68.5%) accessed services at their campus Counseling and Psychological Services center at least once. This finding contradicts earlier findings that the majority of college students with mental health needs do *not* seek formal mental health treatment. It may be that this particular sample (all of whom experienced mental health symptoms and were first diagnosed in high school) were more likely to seek help from campus staff than college students whose symptoms first manifest after entering higher education.

***Student Disability Services and academic accommodations.*** In the qualitative strand of this study, only six of the interviewees (23.1%) accessed academic accommodations at some point during college. Numerous other interviewees claimed to either not know about these resources on their campuses, or not comprehend that they might meet criteria for utilizing them. The focused code *Are those services for me?* captures this confusion. The current study's quantitative findings show that most survey respondents (60; 76.9%) do not know what IDEA or ADA are, nor do they understand

how this legislation might apply to them in college. Only 31 survey respondents (39.7%) utilized academic accommodations at some point in college, meaning that approximately 60% did not. Among those who did utilize accommodations, the most common reported reason for doing so was "because they help me to succeed academically," given my 22.6% of respondents (see Figure 6.3.3). And among those not utilizing accommodations, the most common reason given was "I don't need them" (endorsed by 29.5%), with the second most common reason being "I don't identify as someone who has a 'disability'" (endorsed by 21.8%). (See Figure 6.3.5). And, finally, 25 of the 31 respondents who did utilize accommodations (80.6%) felt that their experience with Student Disability Services was, overall, "positive."

The above findings complement existing literature related to students with disabilities in college. Newman et al. (2011) found that students with serious mental health conditions are the most likely of any disability group to *not* inform their college or university of their disability status, with 21% not reporting, vs. 3 to 15% of students in other disability categories. Salzer, Wick, and Rogers (2008) found that slightly less than half of students with psychiatric disabilities request accommodations or work with a disabilities office, and that many fear the consequences of disclosing their condition. In addition, Salzer (2012) found that among current and former college students with psychiatric disabilities who did obtain some sort of academic support, the majority reported a fear of being stigmatized by faculty and a sense that faculty was uncooperative or unreceptive to their requests for accommodations. These students also reported less engagement on campus and poorer social relationships than their peers. There is also evidence (Ellison et al., 2013) that students with psychiatric disabilities do not seek help

because they believe student disability services offices to be "unknowledgeable or incompetent" (p. 20). And, finally, there is a general lack of awareness among students with psychiatric disabilities regarding accommodations or their rights to receive them (Collins & Mowbray, 2008; Dobmeier et al., 2011; Salzer et al., 2008).

**Social Integration.** Socially, the interview participants described thoughtfully carrying out "strategic disclosures" to share select details of their mental health histories with trusted friends, classmates, roommates, and other peers (more on this in RQ #2, below). A sub-set of students identify as mental health advocates and are members of (or lead) various mental health related campus clubs and organizations. This advocate identity gives them a sense of purpose (FINDING PURPOSE) and connects them with like-minded peers (RELATING FOR RECOVERY), as well as with classmates who also have lived experiences of recovery. These social interactions likely increase the students' over-all sense of social integration in college. Indeed, there is strong evidence from existing literature that membership in peer support groups and social clubs is beneficial for adults with serious mental illness both medically and socially (Dumont & Jones, 2002; Magura, Laudet, Mahmood, Rosenblum, & Knight, 2002; Powell, Hill, Warner, Yeaton, & Silk, 2000; Roberts, Salem, Rappaport, Toro, Luke & Seidman, 1999), but outcomes of membership in such groups are just beginning to be explored among adolescents and young adults (Burns & Birrell, 2014).

There is emerging evidence that group membership does benefit youth, however. In one qualitative study of self-help support group membership for youth with mental health challenges, Dadich (2010) found that "rather than being seen as young people with a debilitating issue who lack the ability to engage socio-politically in changing their

situations…[the participants] were able to actively engage in collectively reflecting on and transforming their own marginalization" (p. 108). The youth also benefited from the pro-social relationships they formed with other members, as the group buffered against outside experiences of social exclusion and discrimination. Here, participation in a group or club may spark a sense of "purpose," and purpose is essential to both youth development (Damon, Menon, & Bronk, 2003) and mental health recovery (Anthony, 1993).

Even for the students who do not "come out" to the majority of their peers in college, there is a consensus among the interviewees that *friends can help you,* and that peer networks and social supports are key to recovery, as well as to thriving in college. In addition, many of the interviewees expressed confidence that just as their friends support them, they also can competently support others (*It goes both ways*), often relying on their own lived experiences to share examples of healthy coping strategies with peers.

Another key to social integration that emerged in the qualitative data is the need for a SAFE SPACE in which to live, learn, work on one's recovery, manage symptoms, disclose if desired, be alone with necessary, and connect with peers. As the late, great, Maya Angelou wrote, "The ache for home lives in all of us, the safe place where we can go as we are and not be questioned." This desire for a place to be safe and "at home" was evident in many of the interviewees' descriptions of their college experiences. Whether the "space" was relational or physical, the study participants greatly valued – and often went about creating – places where they felt safe and able to be their authentic selves.

Seven of the interviewees (27% of the qualitative strand) had TIME OUT OF SCHOOL when they took *Medical leaves* in college due to their psychiatric symptoms. In

addition, 17 (22%) of the survey respondents experienced at least one hospitalization in college, making this a fairly common occurrence. Just as there is a rich body of literature pointing to the importance of social supports, social inclusion, and friendships for mental health recovery (Bradshaw, Armour, & Roseborough, 2007; Jones et al., 2015;), there is growing evidence that working and/or attending school can offer a sense of purpose essential to recovery, as well (Ellison et al., 1999; Ellison, Rogers, & Costa, 2013; Walsh & Tickle, 2013). In the current study, the interviewees who took psychiatric medical leaves all spoke wistfully of the time they "lost" while out of school. They described burgeoning friendships cut short, a lack of intellectual stimulation once they were at home, loss of a student identity, forfeiture of a place in their entering cohort, and – ultimately – a loss of sense of purpose. For them, time out of school was time "lost." Extended periods of inactivity (commonly associated with time out of school or work) have profound negative effects on self esteem, mental and physical health, and well-being in the general population (Blustein, 2008), and it is likely that these negative effects not only exist, but are even more copious and detrimental to people already struggling with mental health challenges.

**Supported Education as an alternative to TIME OUT OF SCHOOL?**

Supported education is a model within the broader psychiatric rehabilitation movement to assist people with serious mental illness in fulfilling educational goals. Programs modify existing educational contexts by making them more supportive for students with psychiatric disabilities. Karen Unger (1991; 2007) and her colleagues at the Center for Psychiatric Rehabilitation at Boston University recognized that one of the major problems for young adults with psychiatric disabilities is that onset of mental

illness often occurs between the ages of 18-25, just as young people face choices related to higher education, professional pathways, and forging meaningful intimate relationships. Development is disrupted, and even if symptoms abate and individuals recover, social and emotional development can remain impaired or delayed. Unger believed that higher education affords students an opportunity to revisit a critical developmental task while simultaneously maturing socially and vocationally.

There is limited formal research on Supported Education, but findings to date show increases in steps toward postsecondary education, as well as in actual college enrollment and competitive employment; increases in self-esteem, empowerment, and quality of life; and a high level of consumer satisfaction with supported education programs (Collins, Mowbray, & Bybee, 1998; Cook & Solomon, 1993; Hoffman & Mastrianni, 1993; Mowbray, Collins, & Bybee, 1999)" (Marrone, 2004, para. 12). In addition, evidence shows that many adults with psychiatric disabilities have the desire, motivation, and educational background to attend college (Mowbray, Megivern, & Holter, 2003). Despite these findings, however, there is related evidence that educational disabilities specialists do not have much systematic knowledge regarding the number of people with psychiatric disabilities, or how they are best served (Benton, Robertson, Tseng, Newton, & Benton, 2003; Sharpe, Bruininks, Blacklock, Benson, & Johnson, 2004). Collins and Mowbray (2005) collected survey data from 597 college disability offices in ten states. The mean percentage of all disabled students with a psychiatric disability was 18%, and approximately 40% of the respondents reported Supported Education programming available either on their campuses or in their regions. However, only 37% of this subsample of respondents reported having moderate or extensive

involvement with these programs. That said, there is great potential for Supported Education programs to help students who might otherwise take medical leaves stay in school. In addition, institutions of higher education have an opportunity to partner with Supported Education programs in their areas – or to adopt or develop their own campus-based programs to promote "education for rehabilitation" more broadly. As noted at the close of Chapter Five, the core code that emerged in the qualitative strand of this study is EDUCATION FOR REHABILITATION, which is the process of successful transitions into higher education, integration, and continued recovery for emerging adult college students with psychiatric disabilities. (See Figure 7.3.3 for detailed recommendations on rehabilitating "integration: to college at both the individual and institutional levels.)

**RQ #2 To whom and why do youth and EAs with PDs make mental health disclosures in educational contexts?**

In order to access help, social supports, and professional treatments and services, it is necessary to tell people about one's mental health or psychiatric disability status. And in educational contexts, decisions related to disclosure can mean the difference between accessing needed academic accommodations, and school failure.

Disclosure is not dichotomous, it is a complex process - a calculus of past personal experiences with disclosure, current academic and relational contexts and needs, and anticipated reactions to a future disclosure. The reasons to disclose, or not, in educational contexts are multiple, complex, and both individual and context-specific. Just because a college student chooses to confide in a trusted roommate does not mean that he or she will choose to speak with an on-campus mental health professional, Student Disability Services staff member, or faculty member. When to tell, why, how, and to whom are all essential questions that a young adult with a psychiatric disability must

negotiate while simultaneously navigating the new landscape of higher education more broadly.

**Disclosures to Peers and School Staff.** Although some study participants chose not to disclose their mental health status to college peers or staff on campus at all (15; 19.2% of the full 78 sample), most (63; 80.8%) chose to share some aspect of their psychiatric history with at least one peer on campus, and some (41; 52.6%) also disclosed to a campus-based professional. Among those who disclosed to college staff, 31 (39.7%) told a Student Disability Services staff person, and 50 (64.1%) told a mental health professional at the campus counseling center.

***Reasons to disclose.*** There are several reasons for making disclosures to peers and faculty. The most common reasons given for telling peers in high school were "because it was a relief to not keep it a secret," and "so people could support me if I needed help managing my mental illness." In contrast, the most common reasons given for telling peers in college were "so my peers could understand me better," and "in order to share details of my life and deepen friendships." And regarding disclosing to school faculty or staff, the most common reason given for telling high school staff was "only when it was so obvious, I could not hide it," while the most common reason for telling college staff was "so they could understand me better." Disclosures in college, whether made to peers or campus staff, were most likely made "so they could understand me better." This reason is linked both to identity development in emerging adulthood ("who am I?"), and to young adults' social interactions ("who am I with this particular group of people, and how do they perceive me?"). Identity and relationships are distinctly different in college than in high school, and as young adults' sense of identity in various domains

becomes more secure, it is likely that they become more comfortable sharing intimate parts of themselves with select others.

There is limited literature addressing mental health disclosures in higher education, and most existing studies show that post-secondary students prefer not to disclose in educational settings (Corrigan et al., 2016; Gruttadaro and Crudo, 2012; Kranke et al., 2013; McAuliffe et al. , 2012; Venville and Street, 2012; Venville, Street, & Fossey, 2014). This is despite evidence showing that people who have disclosed their mental health experiences report higher personal empowerment and quality of life, while people who keep their mental illnesses secret experience negative effects such as diminished self-esteem (Corrigan et al., 2010). There is also evidence that when students do disclose, it is usually out of "desperation to avert another academic failure" (Venville et al., 2014, p. 792), which is akin to the current study's focused code, *Forced Disclosure*, in which students feel compelled to "come out" only after their symptoms become obvious, or they face failing a class.

It is important to note, however, that existing studies on mental health disclosures in higher education focus on student disclosures to college campus faculty and staff, not to their same-aged classmates and peers. The current study helps to address this gap in the literature. That said, the most common reason given *not* to disclose in college was "I don't want special treatment" (see Figure 6.9.1). This finding supports earlier evidence (Stein, 2012) that some students choose not to disclose out of concerns regarding how they will be perceived, and/or that faculty will dismiss their challenges "as an excuse" (p. 173).

In addition to the reasons for disclosure captured on the survey, the majority of interview participants (23; 88.5%) described "strategic disclosures" (THERE'S SOMETHING YOU SHOULD KNOW ABOUT ME) to one or more close friends or trusted mentors in order to (1) increase the intimacy and quality of a relationship; (2) prepare friends to be sympathetic and well-informed supporters; (3) better equip peers and campus staff to assist in case of a psychiatric emergency; or (4) explain a prolonged absence or sudden drop in grades to faculty.

In addition, 23 survey respondents disclosed in their college application essays (29.5%), while 6 interviewees (23.1%) did; however, nearly *every* interviewee admitted to at least *considering* whether or not to share this aspect of themselves in their application essays. Among the survey respondents who disclosed in their college essays, the primary reason given for doing so was "to show the admissions committee that I have overcome serious obstacles." And among the interview participants who disclosed in essays, reasons given included "because it's an important part of me," "because it shows I'm resilient," "because I want to be a neuroscientist, and this professional interest stems from having OCD," and "because I had a lot of absences and it affected my grades."

Given the likelihood that one quarter or more of students with psychiatric disabilities may disclose in college applications, institutions of higher education - especially Admissions Committees - need to be better equipped to receive this type of information. As Jake explained (see Chapter 5, pp. 143-144), without clear policies regarding privacy and confidentiality, information meant solely for an admissions officer may be shared with the campus counseling center, even if this is not the student applicant's intent.

**2.a. Do disclosures change as students move from high school to college?**

Twice as many respondents disclosed to peers in college than to peers in high school (63 disclosed to at least one peer in college [80.8%], while just 31 [39.7%] disclosed to at least one peer in high school). In addition to the frequency of disclosures to peers increasing in college, the recipients are different. In high school, disclosures to peers were most likely made to "a best friend," while in college, disclosures to peers were most likely made to "certain friends." These findings suggest that both secondary and post-secondary institutions would do well to consider implications for student disclosers, and well as for their peer recipients. Universal mental health literacy training, as well as "disclosure training" for youth at the high school level could be an effective strategy to prepare adolescents to both give and receive mental health disclosures safely and appropriately.

**2.b. What are others' reactions to students' mental health disclosures in college?**

***Peer Reactions to Disclosures.*** Perceptions of peers' reactions to disclosures are represented in Figure 6.7.1. The two most common perceived reactions from high school peers are that they "treated me the same afterwards" (22 endorsements; 28.2% of the survey sample) and that they "listened respectfully" (19; 24.4%). The two most common perceived peer reactions in college are that they "listened respectfully" (56 endorsements; 72.8% of the survey sample) and "accepted me" (53; 67.9%). There is also a significant difference in the number of high school and college endorsements of "listened respectfully" and "accepted me," with both types of reactions perceived to be higher from peers in college.

These findings have significance because of the afore-mentioned empirical evidence that most college students do not prefer to disclose mental health challenges in educational contexts. This study's finding that disclosures at both the high school and college level are perceived to be met with positive reactions from peers supports the need for disclosure and receiver training for students in school settings. If more students realized that their friends are likely to accept them after mental health disclosures, such disclosures might become more common. And because mental health disclosures to peers at the college level predict use of campus-based counseling services (see 3.c., below), institutions should consider developing and implementing interventions to promote strategic disclosures to select peers.

***School Staff and Faculty Reactions to Disclosures.*** Perceptions of faculty and school staff reactions to disclosures are represented in Figure 6.4.7. The most common perceived staff reactions in high school are "listened respectfully" and "understood me," while the two most common reactions in college are, first, "accepted me" and, second, both "understood me" and "treated me the same afterwards." There is also a significant difference in the number of high school and college endorsements of "accepted me," "treated me better afterwards," and "seemed uncomfortable." With regard to the latter, half the number (5) of college faculty or staff are perceived as being "uncomfortable" after receiving a mental health disclosure than were their high school faculty counterparts. This may be because higher education staff members are exposed to more students with mental health disorders, and/or that they are more familiar, on average, than secondary school staff with policies related to academic accommodations for students

with disabilities. This potential difference in secondary and post-secondary school staff reactions to mental health disclosures would be a rich avenue for future research.

**RQ #3 What are the relationships among Disclosure, Institutional Integration, and Recovery for EA college students with PDs?**

**3.a. Does general level of psychiatric disability disclosure in HS predict disclosure in college?** The mean reported High School Disclosure Computed Score is 7.96, while the mean College Disclosure Computed Score is 13.44. These scores are significantly different (see Table 6.8.2), showing a change in level of disclosure over time. (Also see Figure 6.4.2, which depicts trends in level of disclosure over time.) This means that disclosure in high school does not predict disclosure in college (see Table 6.12.1.).

**3.b. Does PD disclosure to college peers predict disclosure to college faculty?** Yes, psychiatric disability disclosures to college peers accounts for 5.6% of the variance in disclosures to college faculty (see Table 6.12.2). This is a fairly small, but significant, percentage.

Given that disclosure to college peers predicts disclosure to faculty, interventions to promote strategic disclosures to peers could lead to increased levels of disclosure to faculty. This, in turn, could have the effect of faculty learning more about PDs, related federal legislation such as the ADA, and any campus policies regarding accommodations for students. These possibilities require further research.

**3.c. Does PD disclosure to college peers predict use of campus-based counseling and psychological services (CAPS)?** Yes, psychiatric disability disclosures to college peers predicts the use of campus-based counseling and psychological services (see Table 6.12.4). Approximately 15% of the variance in use of on-campus CAPS can be

explained by disclosure to college peers, which is significant. As in 3.b., above, this finding provides support for increasing disclosures to peers, as they can (1) lead to more social support for students with mental health challenges, and (2) increase disclosures to and help-seeking from CAPS.

**3.d. Does PD disclosure to college peers predict use of Student Disability Services (SDS) on campus?** No, psychiatric disability disclosures to college peers do not predict use of Students Disability Services (see Table 6.12.3). Students, on average, may not know of SDS. More may know of, and recommend, seeking services at CAPS.

**3.e. Is PD disclosure in college associated with institutional integration?** Yes, over-all level of PD disclosure in college (aka "College DISC Computed") predicts IIS total score (see Table 6.15.2). Approximately 11% of the variance in the total IIS is accounted for by the College Disclosure Computed score. In addition, College DISC Computed predicts two of the IIS subscales: IIS subscale #1, *Peer Group Interactions* (Table 6.15.3), and subscale #2, *Interactions with Faculty* (see Table 6.15.4). Higher PD disclosure predicts higher institutional integration, and Tinto's theory of institutional integration (1975; 1993) states that greater integration predicts college degree completion. We can assume, then, that a greater level of disclosure is correlated with a higher likelihood of degree completion, and given the high dropout rates for college students with mental illness, this is an important finding.

**3.f. Is PD disclosure in college associated with recovery?** Yes, College DISC computed predicts total Recovery Assessment (RAS) score (see Table 6.16.2). Fifteen percent of the variance in RAS can be explained by College DISC. In addition, College DISC computed predicts all five of the RAS subscales: #1 Personal Confidence and

Hope; #2 Willingness to Ask for Help; #3 Goal and Success Orientation; #4 Reliance on Others; and #5 Not Dominated by Symptoms (see Tables 6.16.3 through 6.16.7). If higher PD disclosure in college predicts higher RAS scores, then institutions of higher education should promote strategic disclosures among college students with mental illness.

**3.g Is institutional integration associated with recovery?** Yes, RAS total score predicts Institutional Integration (IIS) total score (see Table 6.17). RAS accounts for 29% of the variance in total IIS score. Since greater perceived recovery predicts greater integration, and since Tinto's theory of college integration predicts degree completion (see above), institutions of higher education should promote strategic disclosures among college students with mental illness. As mentioned in 3.f., above, this could lead to more students completing their college degrees.

**Significance of Findings**

The findings of this study can be used to educate secondary school and higher education faculty, staff, and administrators, as well as aspiring college students and their families, about opportunities for college preparation, transitions, and integration for young adults with mental illness. While other studies (see Corrigan et al., 2016; Kranke et al., 2013; McAuliffe et al., 2012; Venville and Street, 2012; Venville, Street, & Fossey, 2014) have looked specifically at students' attitudes and behaviors related to disclosing to college faculty and staff, disclosures to peers have been overlooked in the literature. In addition, the current study explores disclosures of serious mental health conditions in college and in high school, which has not been done previously. My finding that confiding in peers is positively and significantly associated with both disclosing to

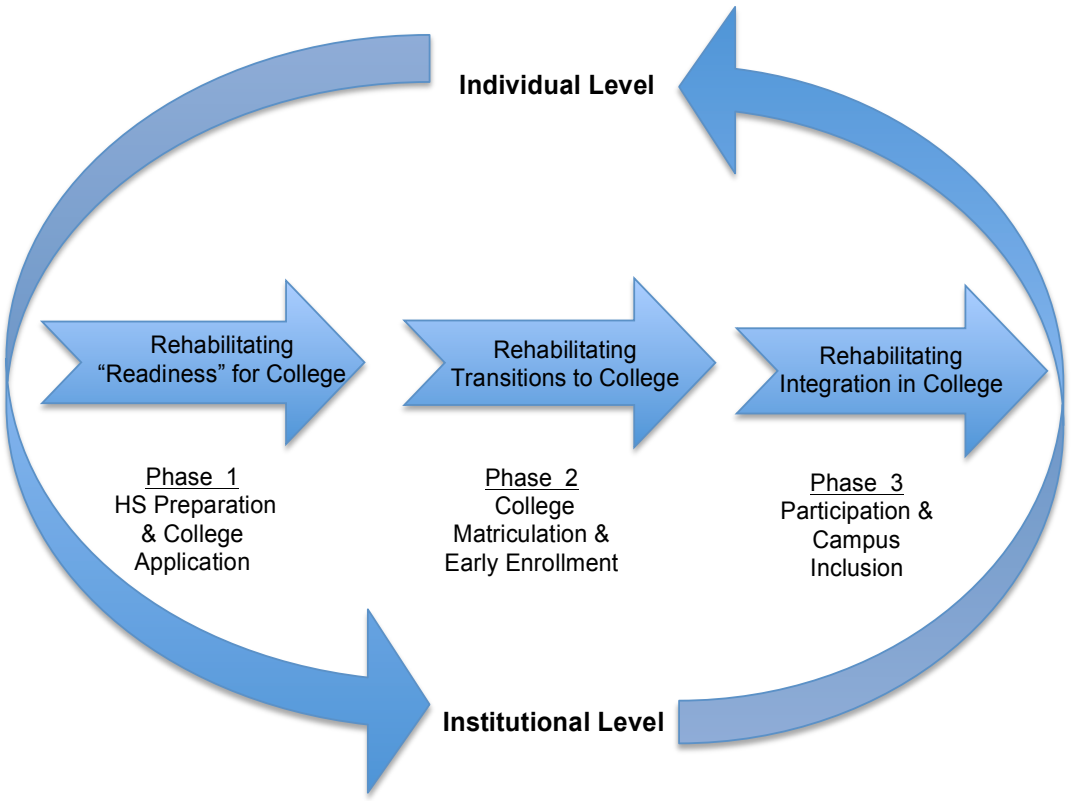
faculty/staff, *and* to using campus-based counseling or psychological services has important implications. If the majority of existing evidence (Venville, Street, & Fossey, 2014) proposes that disclosing to school staff increases students' access to services, it may be that interventions to promote strategic mental health disclosures to trusted peers can also promote disclosures to mental health professionals on campus. And given that students, on average, are hesitant to ask for mental health help or services, utilizing friends and peers as helpers and "gatekeepers" to accessing services could be a boon for students with psychiatric disabilities and campus communities more broadly. In addition, training college students to be helpful recipients of disclosures who then can suggest seeking services at campus CAPS could help students in need to access help prior to mental health or academic crises. This, in turn, could mitigate the need for psychiatric medical leaves, and could lead to more time in school and a higher likelihood of "on time" graduation, which the students in this study report as highly important to them.

**Implications and Recommendations**

In order for the grounded theory of "Education for Rehabilitation" presented at the end of Chapter Five (see pages 168-170) to be useful in applied settings, I believe that it can – and should – be expanded beyond the individual level to include the "institutional" level, and the dynamic interaction of student and school over time in the service of both education and rehabilitation. Just as Disability Studies in Education conceives of "disability" as a social construction and not inherent to an individual (Valle & Connor, 2011), it is necessary to consider how educational institutions themselves co-construct "psychiatric disability" and influence the experiences and trajectories of students, while these same students in turn negotiate and shape campus environments.

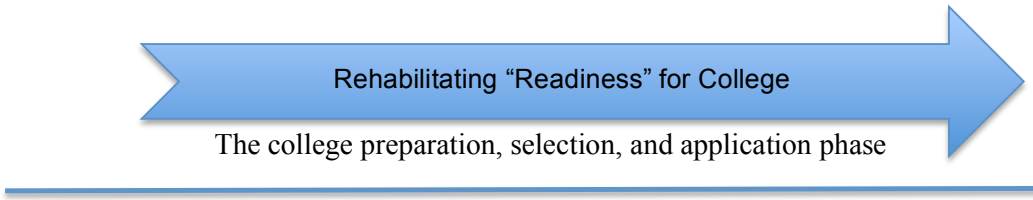
Understanding a student's individual process of "education for rehabilitation" ultimately informs how institutions of higher education can innovate to better support these students. This latter concept can be described as "Rehabilitating Education," which takes place in multiple phases (see Figure 7.2): (1) rehabilitating the concept of college "readiness" so that students with mental illness are supported in their college searches and application endeavors; (2) rehabilitating transitions into college so that students can matriculate in higher education and successfully navigate the early stages of college; and (3) rehabilitating integration into higher education, so that students can participate authentically in college and experience both academic and social inclusion. Each of these three phases combines the individual level (student) with the institutional level (high school and college) in a dynamic model of successful transitions to and through college for students with psychiatric disabilities. Specific recommendations to support Rehabilitating Education, and informed by the grounded themes and survey findings from this study, are given in Figures 7.3.1, 7.3.2 and 7.3.3.

Figure 7.2 Rehabilitating Education: a model of individual level (student) and institutional level (high school and college) interaction in successful college transitions for students with psychiatric disabilities




Here, a preliminary model for how individual students and institutions of higher education can work in concert over time is presented. Specific recommendations for action regarding *how* each level can support comprehensive "education for rehabilitation" throughout the stages of college preparation, transition, and integration are presented in Figures 7.31, 7.3.2, and 7.3.3.

Figure 7.3.1 Recommendations to support Rehabilitating Education Phase 1




Individual Level – High School Student

- Practice self-advocacy and *learn about laws that protect your rights*
- *Access needed mental health services and supports* (within and outside of school)
- Access appropriate academic accommodations, if/when needed
- Consider whether, when, to whom, and *how to disclose in support of educational and recovery goals (including in college application essay)*
- Practice and skills-building related to disclosure
- *Explore colleges' mental health and academic services and supports*
- *Plan for continuation of mental health treatment once in college*
- Develop a version of an "Individualized Education Plan" for college

Institutional Level – Secondary School

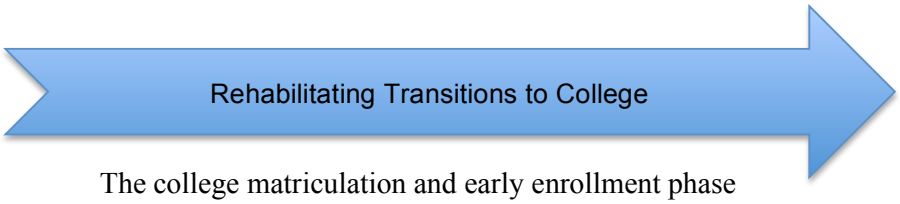
- Understand that majority of students with mental health challenges have not been identified; they are "invisible" and may struggle at school socially and academically
- Offer guidance and counseling to students with mental challenges regarding *college selection and application.* For example:
  - With student, investigate mental health services offered by various universities
  - With student, explore pros and cons of moving away vs. living at home in college
  - Share info regarding IDEA and the *need for student to advocate for self and request own academic accommodations in college*
- *Create "safe spaces" at school* for youth with mental health challenges to connect, educate, advocate and "hang out" (e.g. student-run clubs)
- Commit to school-wide inclusiveness that includes mental health conditions
- Acknowledge that ~ 75% of HS students will disclose to someone at school, and that disclosures to peers are much more likely than to teachers or other staff
- Understand that for students who do *disclose to school staff, teachers are just as – or more - likely to be recipients of disclosures as school counselors*
- Offer guidance and policies to staff, re: *what to do if/when a student discloses a psychiatric disability* (in class, an assignment, or private conversation with a teacher)
- Embed mental health topics in curriculum across disciplines and grades; normalize them
- Provide ongoing mental health literacy and professional development to school staff

Institutional Level – Higher Education

- Advertise campus-based MH services in brochures, campus tours, etc.
- Broaden conceptions of "diversity" and "minority" to include students w/ mental illness
- Actively Recruit a "neuro-diverse" student body
- Create clear policies regarding *what to do (if anything) when students disclose PD in application*

Note: "PD" is abbreviation for "psychiatric disability"; recommendations in *italics* are directly derived from or informed by grounded themes and/or selected survey findings. Remaining recommendations are informed by existing literature.

Figure 7.3.2 Recommendations to support Rehabilitating Education Phase 2




Individual Level – College Student

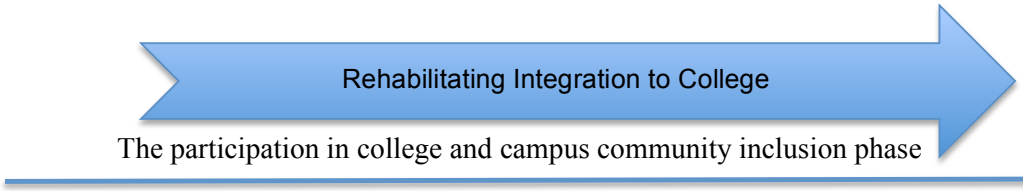
- Harness excitement and enthusiasm about college, but consider that *"wherever you go, there you are"* and that although the context of higher education offers many opportunities for reinvention, becoming a wholly different person may not be feasible
- If treatment worked before entering college, seriously consider continuing it upon arrival
- Understand that *recovery is, in many ways, relational,* and put effort into meeting people and making friends
- Find *safe spaces* to be authentic, honest, and real
- Practice *strategic disclosures* – sharing in ways that support educational, personal, and recovery goals
- Acknowledge that *education and recovery are generally linked*: what is done in support of one will generally benefit the other
- *Consider criteria for having a "disability" and what this label means; learn about services offered on campus through Student Disability Services*
- Practice self-determination and embrace becoming an adult, but know that *even though you* can *do it on your own, that doesn't that mean that you* have *to.*
- Continue to ask for help even when it doesn't seem necessary

Institutional Level – Higher Education

- Create and offer *college "bridge programs"* for youth and young adults with psychiatric disabilities considering higher education
- *Disseminate information and host ongoing activities to publicize* campus-based *Counseling and Student Disability Services*, not just "one-off" events at start of year
- *Disseminate information to all students, re: on- and off-campus community mental health services and supports, and how to access them*
- *Promote "safe spaces"* on campus for community, socializing, support, education, and advocacy related to students with psychiatric disabilities
- Publicize SDS and ensure easy access to *accommodations that best fit needs of student w/ psychiatric disability* (e.g. single room if requested; lighter course-load)
- Advertise campus-based MH services widely and often
- *Prepare all students for possibility that a friend may disclose* a mental health challenge to them; give guidance about supportive and appropriate "receipt of disclosures"
- Create "Supported Education" programs on campus, or work in concert with existing programs situated within community mental health agencies

Note: "PD" is abbreviation for "psychiatric disability"; recommendations in *italics* are directly derived from or informed by grounded themes and/or selected survey findings. Remaining recommendations are informed by existing literature.

Figure 7.3.3 Recommendations to support Rehabilitating Education Phase 3




Individual Level – College Student

- Accept recovery as a process, with ups and downs, progress and set-backs
- Understand that path through college may be marked by periods of "time away," and that being *in and out of school* does not mean "drop out" or "failure"
- Reframe *"lost time"* (time away from school) as time to focus on growth and recovery in other domains
- Work to *find a purpose;* identify goals and activities that are enjoyable and meaningful
- Give back to the community
- Embrace *relating for recovery*: connect with peers who face (or have faced) similar mental health challenges in support of your own – and their - recovery
- Devise and use personal strategies to *strike balance* and manage health, wellness, relationships, and learning. In short, *learn to live* in college
- Understand that *social support "goes both ways":* you are a support to your friends in the same way that they are a support to you

Institutional Level – Higher Education

- Offer ongoing "mental health literacy" training to all students, faculty, and staff
- Create clear and consistent policies for faculty and staff regarding working with students who have PDs. For example
  - *Managing disclosures in the classroom or in written assignments*
  - Providing useful accommodations
  - Implementing a "Universal Design for Learning" framework
- *Acknowledge that participating in college is often vital to students' recovery,* thus expecting students to "go away to get well" may not be optimal
- Acknowledge that students w/ psychiatric disabilities often take *time away from school* and policies should be revised to reflect this and support students' continued progress toward education goals (e.g, medical leave policies)
- Recognize that *most students w/ PDs do not identify at Student Disability Services; devise new and creative ways to engage these students* (e.g. recruitment through peer-based mentoring)
- Concede that *more students w/ PDs seek mental health services off-campus* than on-campus, and that many combine both types of services simultaneously or over time
  - Thus referrals & collaboration with community agencies and providers are needed
- Commit to proactive (not simply reactive) promotion of mental *health* for all
- *Broaden concept of "institutional integration"* so that it moves beyond dual dimensions of "academic" and "social" integration to include *"recovery" integration dimension for students with PDs*

Note: "PD" is abbreviation for "psychiatric disability"; recommendations in *italics* are directly derived from or informed by grounded themes and/or selected survey findings. Remaining recommendations are informed by existing literature.

# Chapter Eight

# CONCLUSION

## Chapter Overview

This chapter includes study limitations and directions for future research, and ends with a call to reconceive "diversity" in higher education to include mental health.

## Limitations of the Study

This study is potentially limited by several factors. Because the qualitative sample for this study is purposive, we cannot necessarily generalize findings to the broader population of young adults with mental illness aspiring to or currently attending college. However, readers may use their discretion to make decisions about whether these findings are potentially "transferable" to other samples or similar populations.

The study does not account for how different psychiatric disabilities or diagnoses may affect students' college transition experiences differently. For instance, there may be particular differences between the experience of young adults who live with major depression, versus those managing anxiety or schizophrenia, and these differences could potentially inform, for example, the design of new academic accommodations for students. In addition, certain recovery experiences for men on college campuses may be different from those for the women. It was particularly challenging to identify and recruit young men to participate in this study, and the fact that only ten men completed the survey, and four participated in interviews is a major limitation. There is evidence that men are less likely to discuss emotions, and to seek help for mental health challenges than women (Oliver, Pearson, Coe, & Gunnell, 2005), and it may be the case that fewer men volunteer to participate in mental-health related research in general. Future work is

needed that investigates adolescent and young adult males' experiences of mental illness, recovery, and education. In addition, it may be that the racial and ethnic minority participants in the study have had significantly different experiences than their white peers. An in-depth exploration of whether and how racial and/or ethnic identity, as well as LGBTQIA identity may influence young adult college students' learning and recovery experiences was beyond the scope of this study, but is a rich area for future research.

We must also ask whether the participants in this study are more likely to "disclose" than non-participants by virtue of their voluntary participation in the study. Meaning, are young adults with mental illness who volunteer to engage in interviews about their mental health and recovery experiences (a) more likely to have disclosed to others in their lives; (b) more likely to have accessed mental health treatment and services because they may have been more likely to disclose and ask for support; and/or (c) more likely to have educational, social, or recovery experiences that are qualitatively different from their peers who may not ever choose to participate in an interview-based study?

Regarding the quantitative dataset, the sample is relatively small, and is not nationally representative. According to a sample size calculator I would have needed to collect data from 384 total respondents in order to be able to generalize to the population of college students with psychiatric disabilities, with a 95% confidence level, and a confidence interval of 5. This figure is based on an estimate of 20.2 million college students attending U.S. colleges part- or full-time in 2014 (National Center for Education Statistics) with approximately 40% of them reporting a mood, anxiety, and/or personality disorder in the past year (Blanco et al., 2008).

In addition to the sample size for the quantitative dataset, a second limitation is that data is dependent on self-report of mental health history, diagnosis, and treatment. No medical, mental health care, educational, or other administrative data were accessed.

Regarding the survey, I recognize the limitations of the survey procedures used in this study and cannot make any claims about the generalizability of the results. There was no obvious source for identification of survey respondents who met the inclusion criteria (age 18-25, currently attending a U.S. college or university, and identifies as having a mood, anxiety or psychotic disorder). Because of this, I recruited participants by contacting youth and young adults mental health organizations such as Youth Move and Let's Erase the Stigma, and I also sent links to campus-based MH orgs and clubs such as Active Minds and NAMI on Campus. That said, the online survey was open to unknown selection bias, and I have no way to assess how representative the respondents are. There is an item on the survey asking whether the respondent is a current or former member of a campus-based mental health club, in an effort to assess whether a large percentage of respondents may have heard of the survey through participation in such a club. Fifty (64%) of the 78 survey respondents claimed membership, so it may be that the sample is skewed toward club membership. This is an important point, as members of college mental health awareness, education, and advocacy clubs who have mental illness may be qualitatively different from their peers with mental illness who are not members (e.g. the former may be more outgoing, social, engage in campus, be more "integrated," and/or their symptoms may be less severe).

In addition, I must acknowledge that it may be the case that study participants may differ from peers in their willingness their disclose, as it may be that young adults

with psychiatric disorders who volunteer to participate in a study about related experiences are more outgoing. This is likely especially so for the interview participants, as they met with me in person and discussed highly sensitive and private issues with great thought and candor. I have to wonder: are these young people, on average, different from the "norm" – if, in fact, there is a "norm" for young adults with mental illness?

**Directions for Future Research**

Though pursuing one's educational goals has been acknowledged as an important part of individual recovery by mental health consumers, providers, and researchers working in the field of psychiatric rehabilitation (Blacklock, Benson, & Johnson, 2003; Collins & Mowbray, 2005; Megivern, Pellerito, & Mowbray, 2003), the institution of education itself, and its potential role in fostering recovery on a broad scale through its policies and practices remains largely unexplored. Currently little is known regarding how both secondary school and higher education experiences might facilitate and/or hinder recovery for American college students managing some form of mental illness (Eisenberg, Hunt, & Speer, 2013; Rickerson, Souma, and Burgstahler, 2004). Thus, the data that were collected and my analyses of them provide a solid foundation for future research.

One area for investigation relates to the long-term educational and professional outcomes for college students with psychiatric disabilities. What are their experiences as they complete their degrees and either continue on for graduate education or move into the working world? This type of study would involve an even longer longitudinal study, following participants through college and for multiple years afterward. An additional area for further research includes exploring the processes, timing, and outcomes of

disclosure - in a wide range of post-secondary settings and with larger numbers of students. This would allow for a deeper exploration of issues raised by the current study. Other related studies might investigate: recovery experiences for young adults who are not college students, as well as those who are high school students; potential differences in experience based on type of mental health condition, severity, or length of time since initial diagnosis; potential differences in educational experiences for students with PDs across races and ethnicities; and a comparison of the experiences of college students with PDs who participate in "Supported Education" programs versus those who do not.

There is also a need to explore the potential benefits of distance-learning versus attending college classes in-person for students with mental illness, as remote learning may afford more anonymity, a greater sense of protection from perceived stigma, and a mechanism to deal with feelings of social anxiety. There is also the need for development of a validated measure for psychiatric disability disclosure in different setting, with the goal of developing a tool to assess where adolescents and young adults line on a "disclosure continuum." Since findings from the current study show that disclosure to peers in college predicts institutional integration, it would be helpful to find out where students are in terms of their likelihood to disclose, as part of a broader effort to promote strategic disclosures and school integration.

And finally, future research might look at the effects of "education for rehabilitation" interventions that target the developmentally appropriate milestones of both adolescents and young adults with serious mental illness. Three ideas for interventions informed by the findings from the current study are: (1) College and career "readiness" for youth with psychiatric disabilities, which would entail adding

components to an existing "readiness" framework in order to make it appropriate and effective for youth with mental illness; (2) developing a college "bridge" program for high school graduates to participate in prior to matriculating into college. Modeled on existing "bridge" programs that generally take place over the Summer after high school graduation and are designed to help youth transition into higher education, this program would be targeted for new college students with psychiatric disabilities to ensure that students who may not have received "education for recovery" guidance and "college readiness" supports in high school can still learn and practice useful skills, and gain practical knowledge that will set them up for success in college. And (3) creation of campus-based "mental health peer ambassador" programs for college students with psychiatric disabilities, wherein current students with PDs mentor new and incoming students, helping them to integrate into campus life, and ensuring that they are introduced to services like SDS and CAPS by a friendly peer ally.

**A Final Thought: Reconceiving "diversity" in higher education to include mental health**

"Diversity" in higher education should not be limited to demographic characteristics of students and faculty. True diversity should also exist in pedagogical approaches to disability, scheduling of the "academic calendar", and in ways of "doing" higher education. (For example: flexible class schedules, part-time options, alternatives to the conventional academic calendar, and emphasizing meaningful engagement in learning, rather than exclusively focusing on physical presence, "persistence," and individual achievement.)

In her paper on diversity in higher education, Marta Tienda (2013) explains "integration is not an automatic by-product of campus diversity; therefore, to harness the benefits of diverse student bodies, institutional leaders must pursue deliberate strategies that promote inclusion" (p. 467). Though Tienda focuses on racial and ethnic diversity in her article, the points she makes are equally applicable to students with mental health challenges. The fact that they are not mentioned or considered in this, and countless other education papers on "diversity" and "minority students," is evidence of just how marginalized students with psychiatric disabilities remain. Even in work related to students with "disabilities," youth and young adults with mental health challenges are often overlooked and not considered. They are, arguably, the last – and the largest – group of "minority" students on college campuses today. We just don't see them.

Tienda makes the case that although

> a diverse student body provides the necessary conditions for leveraging educational benefits, it does not guarantee the socially legitimate goal of integration (Lehman, 2004). Rather, because of human tendencies to sort into 'islands of comfortable consensus' (Haring-Smith, 2012), integration must be deliberately cultivated through interactions that engage the diverse life experiences of students from different racial, geographic, religious, and political backgrounds. (p. 470).

And the same call to action applies to not just *including* young adults with psychiatric disabilities on our college campuses, but to intentionally *integrating* them into campus communities. The challenge, of course, is how to do this in an effective way. Just as using racial preference as a way to diversify college campuses remains contested by many, it is likely controversial to propose that institutions adopt a "mental health preference." But I will do this nonetheless.

Where affirmative action and racial preference policies to diversify campuses are ostensibly in an effort to encourage more minority students to apply, be accepted, and matriculate into schools, a "mental health preference" is more about letting applicants and current students know that different types of minds, brains, and recovery experiences are not just included, but embraced. I take a cue from the "neurodiversity movement" here, which employs a positive "diversity" perspective similar to biodiversity to replace current "disability" discourse. The movement posits that differences like autism and ADHD are not deficits or pathology, but the result of normal and natural human variation (Armstrong, 2012; Jaarsma & Welin, 2012; Pollack, 2009). However, I move beyond limiting this construct to autism spectrum disorders, ADHD, and various learning differences, and adapt it to include the vast array of mental health disorders and diagnoses common among college students today. The fact is, we don't need to recruit them and assure that enrollment numbers are high, in the way that affirmative action plans do; these students are already aspiring to college, and are already there. Instead, institutions of higher education would do well to acknowledge this, and to put funding and resources into supporting "mental health diversity." This could take the form of advertising relevant resources to potential applicants, celebrating a broad conception of "diversity" and putting this into action, and helping all students to remain in school for as long as possible and in whatever way(s) are most beneficial to them.

These suggestions likely fly in the face of conventional wisdom, and certainly of the economic model of private institutions of higher education, where students who take medical leaves or "drop out" no longer pay tuition. However, if colleges and universities were better equipped to welcome and support students with psychiatric disabilities, fewer

might find it necessary to take time entirely away from school to address their health. Indeed, just as Disability Rights scholars and activists remind us that "accessibility" can benefit everyone regardless of disability status (Malhotra & Rowe, 2014), so, too, can pedagogical and policy changes related to supporting and maintaining good mental health on campuses benefit everyone.

APPENDIX A

University of Pennsylvania
Office of Regulatory Affairs
**3624 Market St., Suite 301 S**
Philadelphia, PA 19104-6006
Phone: 215-573-2540/ Fax: 215-573-9438
**INSTITUTIONAL REVIEW BOARD**
(Federal-wide Assurance # 00004028)

09-Sep-2014

Howard C. Stevenson
HOWARDS@GSE.UPENN.EDU
GRAD SCH OF EDUCATION
3700 Walnut Street
Philadelphia, PA 19104-6216
Laura Murray
lamurray@gse.upenn.edu

| | | |
|---|---|---|
| PRINCIPAL INVESTIGATOR | | HOWARD C. STEVENSON |
| TITLE | : | College in Mind: A mixed-methods study of how emerging adults with psychiatric disabilities prepare for and transition to college |
| SPONSORING AGENCY | : | NO SPONSOR NUMBER |
| PROTOCOL # | : | 820944 |
| REVIEW BOARD | : | IRB #8 |

Dear Dr. Howard Stevenson:

The above referenced protocol and was reviewed and approved by the Executive Chair (or her authorized designee) using the expedited procedure set forth in 45 CFR 46.110, category 6,7, on 08-Sep-2014. This study will be due for continuing review on or before 07-Sep-2015.

**Approval by the IRB does not necessarily constitute authorization to initiate the conduct of a human subject research study.** Principal investigators are responsible for assuring final approval from other applicable school, department, center or institute review committee(s) or boards has been obtained. If any of these committees require changes to the IRB-approved protocol and informed consent/assent document(s), the changes must be submitted to and approved by the IRB prior to beginning the research study.

If this protocol involves cancer research with human subjects, biospecimens, or data, you may not begin the research until you have obtained approval or proof of exemption from the Cancer Center's Clinical Trials Review and Monitoring Committee.
The following documents were included in this review:

_HSERA Initial Expedited Submission (confirmation code: bgdchjhf) Submitted on: 9-04-2014 _Cover Memo, dated 9-04-2014 _Dissertation Recruitment Flyer, uploaded on 9-04-2014 _Consent Form for Online Survey, uploaded on 9-04-2014 _Text for Social Media Recruitment, uploaded on 9-04-2014 _Consent Form (Student/Participant) Version 1, 8/2014 When enrolling subjects at a site covered by the University of Pennsylvania's IRB, a copy of the IRB approved informed consent form with the IRB approved from/to stamp must be used unless a waiver of written documentation of consent has been granted.

If you have any questions about the information in this letter, please contact the IRB administrative staff. Contact information is available at our website: http://www.upenn.edu/regulatoryaffairs.

Thank you for your cooperation.

Sincerely,

Heather Emery
IRB Administrator

# University of Pennsylvania

## CONSENT FORM

**Project Title:** *College in Mind: A mixed methods study of how emerging adults with psychiatric disabilities prepare for and transition to college*

**Investigator:** Laura C. Murray, PhD(c), MSEd, MA
Applied Psychology & Human Development
Graduate School of Education
University of Pennsylvania

**Faculty Advisors:** Howard Stevenson, PhD
Applied Psychology & Human Development
Graduate School of Education
University of Pennsylvania

**Background & Purpose:**

More students with psychiatric disabilities are attending American colleges and universities than ever before, yet little is known about their educational experiences prior to their arrival in higher education, or how they navigated the transition to college. You are being asked to participate in a study to explore the skills, strengths, and strategies students with mental illness employ to complete high school and transition into higher education successfully. In addition, I hope to explore how college student make decisions related to disclosing psychiatric disabilities in educational settings.

This study will result in my dissertation, the last requirement for me to complete a PhD in Human Development at the University of Pennsylvania's Graduate School of Education. In addition, I hope that findings from this study will also result in one or more articles to be submitted for journal publication.
You are being asked to participate in this study because you are a young adult who self-identifies as having Depression, Bipolar Disorder, or Schizophrenia, and you are also beginning or returning to college in the Fall of 2014.

**Procedures**
As the researcher, I would like interview you twice over the course of the upcoming academic year. I can meet you at a location and time that is convenient for you, or we can arrange an interview via phone or Skype if that is preferable. Each interview will last for approximately 60-90 minutes.

When writing up findings from the study, I will not use your name, nor will I use the name of your college or university. All participants and schools will be given pseudonyms to protect your privacy.

With your permission, I will record our interview on a digital audio recorder. After the interview, the recording will be transcribed and the original digital audio recording will be destroyed.

**Participants' Rights:**
Your participation in this study is entirely voluntary and you are free to withdraw at any time. You are also free to choose not to answer any questions that you do not wish to answer during our interview. In addition, you may ask that the recorder be turned off at any point if there is something that you do not wish to have recorded.
**Risks**
Your participation in this study does not involve any physical risk. There is the possibility of minimal emotional risk, as the potential discussion of certain events in your life may be upsetting in the moment. I will take measures to minimize this.

**Benefits:**
There may be no direct benefit to you by participating in this research study. However participation may offer an opportunity to reflect on your experiences as a young adult living with a mental illness, as well as a chance to share your story and insights (anonymously) with educators, psychologists, mental health advocates, and other youth who are interested in supporting people to transition to, and through college, successfully.

**Confidentiality:**
As described above, your identity will be protected and your name will not be used.

Unless required by law, only the study's primary investigator (myself), the University of Pennsylvania Institutional Review Board, and/or representatives from the Office for Human Research Protections (DHHS) will have authority to review the study data. We are required to keep your identity confidential.

**Centralized data collection or registries:**
After all interviews are completed, the audio recordings and resulting interview transcripts, as well as field notes from all observations, will be locked in a file cabinet in my office. I will be the only person who will have access to this file cabinet, and after the study has ended all original data will be destroyed.

**Financial Information:**
Your participation in this study will involve no cost to you. As a thank you for your time, you will receive a $25 gift certificate to Amazon after each of our two interviews (a total of two $50 gift certificates).

**Contact Persons:**
If you have any questions about this study you may contact me, Laura Murray (PI) at:
phone (310) 463-9692 or email: lamurray@gse.upenn.edu

If you have any questions about your rights as a research subject, you may call the Office of Regulatory Affairs, Institutional Review Board at University of Pennsylvania: (215) 898-2614.

**Consent:**
I agree to participate in the study described above. I will receive a copy of this consent form after I sign it.

Your Name (printed):

_____

Your Signature:

_____

Your preferred mode of contact and contact info (phone, text, email, or mailing address)

_____

_____

Date

_____

Name (printed) and Signature of Person Obtaining Consent

APPENDIX B


The University of Pennsylvania -Graduate School of Education
Division of Applied Psychology & Human Development

is conducting a research study of

**young adults with psychiatric disabilities who are going to college**

- If you are between the ages of 18-25,
- you have a current diagnosis of a mood, anxiety, or psychotic disorder (e.g. major depression, bipolar, generalized anxiety disorder, obsessive-compulsive disorder, schizophrenia, or schizoaffective disorder),
- you received your diagnosis before beginning college,
- and you will be a full-time or part-time college student in Fall 2014

You may qualify for a research study exploring the experiences of young adults with mental illness and their transitions into higher education.

Eligible participants will be interviewed at a location of their convenience, two times over the course of an academic year. Total interview time will be approximately 2 -3 hours.

Participants will be compensated with $25 gift cards each time that they are interviewed.

Co-Principal Investigator & primary study contact:
Laura C. Murray, PhD(c), MSEd, MA

**For more information** please call: (310) 463-9692
Or email: lamurray@gse.upenn.edu

# APPENDIX C

## List of Online Recruitment Sites

Active Minds - www.activeminds.org

*Contacted multiple chapters at colleges and universities across the country

AttemptedSuicideHelp

@ASH_HELP

Balanced Mind Foundation - www.thebalancedmind.org

Bipolar Foundation

BP Children -www.bpchildren.com

BringChange2Mind.org - bringchange2mind.org

@BC2M

Black Dog Tribe

@FollowBDT

BlackDogTribe.com

CareForYourMind

@CareForYourMind

Depressive and Bipolar Support Alliance - www.dbsalliance.org

Each Mind Matters

@EachMindMatters

End The Stigma

@EndTheStigma

Family and Child Institute

@child_family_ny

Federation of Families for Children's Mental Health - www.ffcmh.org

International Society for Bipolar Disorders - www.isbd.org

The Jed Foundation - www.jedfoundation.org

@jedfoundation

Juvenile Bipolar Research Foundation - www.jbrf.org

Mental Health America - mentalhealthamerica.net

@MentalHealthAm

NAMI on CAMPUS - www.nami.org/namioncampus

*multiple chapters across colleges and universities

National Mental Health Foundation - www.nmha.org

Project LETS - www.letserasethestigma.com

@projectlets

Reach Out USA - us.ReachOut.com

@ReachOutinUSA

Youth Mental Health

@Time4Recovery

Youth MOVE National - youthmovenational.org

@YouthMOVE

# University of Pennsylvania

**CONSENT FORM**

**Project Title:** *College in Mind: A mixed methods study of how emerging adults with psychiatric disabilities prepare for and transition to college*

**Investigator:** Laura C. Murray, PhD(c), MSEd, MA
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This study will result in my dissertation, the last requirement for me to complete a PhD in Human Development at the University of Pennsylvania's Graduate School of Education. In addition, I hope that findings from this study will also result in one or more articles to be submitted for journal publication.

You are being asked to participate in this study because you are a young adult who self-identifies as having a mood, anxiety, or psychotic disorder, and you are also beginning or returning to college as an undergraduate student in the Fall of 2014.

**Procedures**

As the researcher, I would like interview you twice over the course of the upcoming academic year. I can meet you at a location and time that is convenient for you, or we can arrange an interview via phone or Skype if that is preferable. Each interview will last for approximately 60-90 minutes.

When writing up findings from the study, I will not use your name, nor will I use the name of your college or university. All participants and schools will be given pseudonyms to protect your privacy.

With your permission, I will record our interview on a digital audio recorder. After the interview, the recording will be transcribed and the original digital audio recording will be destroyed.

**Participants' Rights:**

Your participation in this study is entirely voluntary and you are free to withdraw at any time. You are also free to choose not to answer any questions that you do not wish to answer during our interview. In addition, you may ask that the recorder be turned off at any point if there is something that you do not wish to have recorded.

**Risks**

Your participation in this study does not involve any physical risk. There is the possibility of minimal emotional risk, as the potential discussion of certain events in your life may be upsetting in the moment. I will take measures to minimize this.

**Benefits:**
There may be no direct benefit to you by participating in this research study. However, participation may offer an opportunity to reflect on your experiences as a young adult living with a mental illness, as well as a chance to share your story and insights (anonymously) with educators, psychologists, mental health advocates, and other youth who are interested in supporting people to transition to, and through college, successfully.

**Confidentiality:**
As described above, your identity will be protected and your name will not be used.

Unless required by law, only the study's primary investigator (myself), the University of Pennsylvania Institutional Review Board, and/or representatives from the Office for Human Research Protections (DHHS) will have authority to review the study data. We are required to keep your identity confidential.

**Centralized data collection or registries:**
After all interviews are completed, the audio recordings and resulting interview transcripts, as well as field notes from all observations, will be locked in a file cabinet in my office. I will be the only person who will have access to this file cabinet, and after the study has ended all original data will be destroyed.

**Financial Information:**
Your participation in this study will involve no cost to you. As a thank you for your time, you will receive a $25 gift certificate to Amazon after each of our two interviews (a total of $50 in gift certificates).

**Contact Persons:**
If you have any questions about this study you may contact me, Laura Murray (PI) at:
phone (310) 463-9692 or email: lamurray@gse.upenn.edu

If you have any questions about your rights as a research subject, you may call the Office of Regulatory Affairs, Institutional Review Board at University of Pennsylvania: (215) 898-2614.

**Consent:**
I agree to participate in the study described above. I will receive a copy of this consent form after I sign it.

_____
Your Name (printed)

_____
Your Signature

_____
Your preferred mode of contact and contact info (phone, text, email, or mailing address)

_____

_____
Date

_____
Name (printed) and Signature of Person Obtaining Consent

**Basic Background**

Name: Interview Date:

Gender: Interview Location:

DOB:

Race/Ethnicity:

Where do you currently live and who do you live with?

Contact Information:

*Phone*

*Email*

*Address*

**High School Info**

Where did you go to high school?

Where did you live and who did you live with in high school?

Did you have an Individualized Educational Plan (IEP) in high school?

When did you graduate from high school (date)?

Approximate HS GPA:_____

Did your high school have a mental health awareness, advocacy, or education club?

_____No

_____Yes. What was it called?_____

Where you a member? _____No _____Yes

**College Info**

What college do you currently attend?_____

When did you first enter college (date)? _____

How far along are you in your undergraduate studies?_____

What is your current Major?_____

Approximate college GPA:_____

What type of degree program are you in? _____AA _____BA/BS

When do you anticipate graduating?_____

If you have attended any other colleges, please list them (and the dates when you attended) here:

Did either of your parents go to college? _____No _____Yes
If YES, who?

**Employment History**

Are you currently working? _____No _____Yes.

If you are working now, what do you do?_____

How many hours a week? _____

What are your future educational or career goals?

**Mental Health History**

What is your current mental health diagnosis (or diagnoses)?_____

How old were you when you first received a diagnosis?_____

Have you ever taken medication for your disorder?_____Yes _____No

Do you take medication for your disorder now?_____Yes _____No

Have you ever been hospitalized for your disorder?_____Yes _____No

If yes, how many times?_____ When was your most recent hospitalization?_____

Have you taken time away from high school due to symptoms? _____Yes _____No

Have you taken time away from high school due to hospitalizations? _____Yes_____No

Have you taken time away from college due to symptoms? _____Yes _____No

Have you taken time away from college due to hospitalizations? _____Yes _____No

Which of the following mental health professionals have you seen for your disorder(s) prior to attending college? (Please check all that apply.)

____Psychiatrist ____Psychologist ____Social Worker

____Primary School Counselor ____Secondary School Counselor _____Other (who?)

Which of the following mental health professionals have you seen for your disorder(s) since beginning college? (Please check all that apply.)

_____Psychiatrist off campus ____Psychologist off campus

_____Other mental health professional off campus

_____Psychiatrist on campus ____Psychologist on campus

_____Other mental health professional on campus ____Other (who?)

Have you accessed any accommodations on campus through the Student Disability Services Office?_____Y _____N

If yes, which ones?

Who do you turn to for support now that you're in college (please check all that apply)?

_____Family _____Roommate(s) _____Friend(s) _____College Faculty

_____Disability Services Office _____Counseling and Psychological Services Center

_____Off-campus mental health service professional(s) _____Campus clergy

_____Other (Please list below):

Have you disclosed to any of the following people on campus? _____Yes _____No

If yes, please check all that apply:

_____Roommate(s) _____Friend(s) _____Faculty

_____Disability Services Office _____Counseling and Psychological Services Center

_____Other (Please list below):

Are you a member of an on-campus college mental health awareness, advocacy, or education club? _____No _____Yes If yes, what is it called?

# APPENDIX F

## Interview Guide, T1

Note: This is the interview guide used in the Fall of 2014 for the initial in-person interviews with study participants.

A statement on the purpose of this study: "…to explore how emerging adults with psychiatric disabilities navigate high school, then prepare for and transition into higher education. In addition, I hope to explore how students make decisions related to disclosing psychiatric disabilities in educational settings."

**PART 1 – Preparation for and Expectations of College**

**I. Basic background**

*See "Interview Summary Form"

**II. Diagnosis and Treatment History**

When talking about your own mental health, what words or terms do you like to use?

(E.g. "bipolar"; "mental illness"; "psychiatric disability"; "serious mental health challenge")

What do you think of the terms above?

What did you know about "mental illness" in general when you were growing up?

Describe the story of first noticing that something was happening with your mental health

Onset?

First change/symptoms?

Any hospitalizations?

Medications?

Any other treatments, services, supports?

How are you doing now?

**III. High School Experiences**

How would you describe your high school?

*Friends & other social supports in high school*

Who did you turn to for support when you were a high school student? Describe that.…

Did you have any friends in HS who also had a psychiatric disability? Explain…

*Being a high school student w/ mental illness*

If you ever went to the hospital or to residential treatment and had to leave school, and then return, what was that like?

If you took medication when in school, what was that like?

Did you ever ask for/receive "accommodations" while you were in high school?

If so, what was your experience receiving these? (Did they help?)

If you had an "IEP" in high school, what was that like?

*Academics*

What helped you to succeed academically in HS (at least enough so that you graduated, and are headed to college?)

What made it challenging for you to succeed academically in HS?

Reflecting back on HS, do you wish that you had done anything differently?

Do you wish that your parents, or the school had done anything differently?

If you could tell the world one thing about what it's like to be a high school student with a [psych disability], what would it be?

**IV. Disclosure in High School**

How did you make decisions about whether to tell anyone about your mental illness (disclose) when you were high school?

Did you disclose to anyone when you were in high school?

If so, when, why, and to whom?

What were their reactions to you telling them about your psychiatric disability?

If you did *not* disclose to anyone in high school, is there a reason for that?

What did parents think about your choices related to disclosure in high school?

And now?

**V. Attitudes, Preparation & Expectations related to college**

When did you first start thinking about going to college?

Did anyone help you to get ready for college?

If so, who were they and what did they do?

Describe the steps you took to get to college

What were you looking for in a college?

If you could do the college application process all over again, would you do anything differently?

If you moved away to go to college, how did you prepare to leave home?

What did you think college would be like before your arrived?

Did you anticipate telling people at college about your past/psychiatric disability?

Why or why not?

Did you give any thought to how you might do that?

Did you plan to access accommodations at the Student Disability Services office?

Did you plan to use the campus counseling or other mental health services?

**PART 2 - Actual Transition to College**

**I. Initial transition to college**

Can you describe first starting college?

What was the most challenging part?

What was the most surprising part?

(And if further along than freshman year in college: What was different between the beginning of your first year and the end of your first year? And now?)

**II. Managing academics related to psych disability**

How have you been doing academically in college? Tell me about that…

Do you have any strategies to manage college? If so, can you tell me about these?....

And how about managing your mental health as a college student?

Have you accessed any academic accommodations here on campus?

Why or why not? Tell me about that…

(And if student has not accessed accommodations: What do you know about Student Disability Services or the Counseling services here on your campus?)

**III. Managing social life related to your psych disability**

Are you involved in any campus activities, like clubs, groups, or sports? Tell me about that…

And what is your social life like in college?

What about drugs and alcohol?

I know these are common on college campuses; how do you make decisions about use?

And are these decisions related to your mental health (and/or use of psychiatric medication) at all? How so?.....

**IV. Relationships**

In addition to your social life in general, what about closer relationships on campus?

Do you have any close friends? What do you like to do together?

Have you told them about your mental health history?

Why or why not?

And if so, how did it come up?

What did you say, and how did they react?

And how about romance and dating – do you have a special person in your life?

Tell me about him or her….

And have you told this person about your mental health history?

Why or why not?

And if so, how did it come up?

What did you say, and how did they react?

And what about roommates or housemates?

And other relationships with classmates & other peers on campus

And what is your relationship like with your family at home?

Has it changed at all since you've started college?

**V. Managing mental health in college**

Finding a new doctor or therapist?

Meds?

Balance (ex: Enough Sleep; good nutrition; regular exercise)

**VI. Time away from school**

Have you ever transferred from one college to another?

What were the reasons for that?

Can you describe what happened?

And what about taking time away from school in college related to your mental health – have you ever done that?

What were the reasons for that? Can you describe what happened?

**VII. Disclosure stories/experiences on college campus**

How do you make decisions about self-disclosure in college?

Have you disclosed to anyone on campus?

If so, when, why, and to whom have you self-disclosed your illness?

And what were their reactions?

Please tell me about any college experiences that have affected your decision *to* disclose.

Please tell me about any college experiences that have affected your decision *not* to disclose.

If you have not disclosed your illness to anyone on campus, is there a reason for that?

What is it like to disclose your disability on campus?

Have your choices around disclosure influenced your friendships & social life on campus?

Do you think that your choices around disclosure have influenced your academic progress or achievement in college?

Why or why not? And if so, how?

**VII. Hopes for the future**

Do you have thoughts about your future? Tell me about that…

What about educationally, beyond this year?

And have you thought about a future career? Tell me about that….

And personally? Where do you see yourself in 5 or 10 years?

***Anything else?.....***

# APPENDIX G

## Sample Interview Guide, T2

*Note that each T2 interview protocol is highly individualized and informed by the particular participant's T1 interview data. The following are the questions that I asked Adam the second time that we met in person, in the Summer after his Freshman year.

Adam – Intv T2 (conducted 7/3/15)

**General Update**

You just completed your Freshman year at XX University. How was it?

What are you doing this Summer?

You mentioned in the Fall that you planed to be a Public Health or Pre-Med Major. Is that still the case?

You also mentioned in the Fall that your future career goal still to do something "psychology or medicine related." What are you thinking now?

Tell me how your living situation panned out this year. I remember that you had some issues with having a roommate and doing tele-psychiatry,

And what are your plans for a living situation this upcoming year?

**Mental Health**

Have you spent any time away from school to manage your manage health since we last spoke?

Have you had any experiences this year where your mental health affected your education?

In Fall 2014, when we last spoke, you were doing tele-psychiatry with your doctor from home. Are you still doing that?

> And you have seen any additional mental health professions here in [city name], either on- or off-campus? Tell me about that….

**Academics and Accommodations**

How have you been managing academically?

In the Fall, you hadn't accessed any accommodations through the Office of Student Disability Services here, but you were considering it. How about now?....

**Social Support**

How has your social life in college been so far?

**Disclosure**

In terms of talking about your mental health and having a diagnosis of bipolar, in the Fall you said that you were "pretty open" with friends. Is that still the case?

Tell me about that….

**Recovery**

What does "recovery" mean to you?

In general, and also for you, specifically?)

Has your mental illness and recovery affected your education?

How so?

Have your educational goals and/or experiences affected your mental health and recovery?

How so?

**College Choice, Transition, and Integration**

Looking back on this first year, what stands out most about your transition to college?

What was easy? Hard?

What do you wish you'd known about college before starting that you know now?

If you had to do this past year over again, would you do anything differently?

Is [university name] a good fit for you? (Would you still choose to go there?)

Is college what you expected it to be?

***Anything else?***

APPENDIX H

Brief Descriptions of Psychiatric Disabilities represented in Sample

**Anxiety Disorders**

Anxiety disorders are psychological conditions marked by feelings of extreme uneasiness, worry and fear. This can interfere with daily activities such as job performance, school work, and relationships (NIMH, 2016). Anxiety disorders are the most common type of psychological disorder, with 12-month prevalence rates of 18.1%. This category of disorder includes agoraphobia, generalized anxiety disorder, obsessive-compulsive disorder, panic disorder, post-traumatic stress disorder, phobias, and social anxiety (Kessler et al., 2005b).

**Anorexia Nervosa**

> "People with anorexia nervosa may see themselves as overweight, even when they are dangerously underweight. People with anorexia nervosa typically weigh themselves repeatedly, severely restrict the amount of food they eat, and eat very small quantities of only certain foods. Anorexia nervosa has the highest mortality rate of any mental disorder. While many young women and men with this disorder die from complications associated with starvation, others die of suicide. In women, suicide is much more common in those with anorexia than with most other mental disorders." (NIMH, 2016)
>
> Text retrieved from: https://www.nimh.nih.gov/health/topics/eating-disorders/index.shtml?utm_source=rss&utm_medium=rss

**Attention Deficit Hyperactivity Disorder (ADHD)**

ADHD is defined as a persistent pattern of inattention and/or hyperactivity-impulsivity that interferes with functioning or development, has symptoms presenting in two or more settings (e.g. at home, school, or work; with friends or

relatives; in other activities), and negatively impacts directly on social, academic or occupational functioning. (American Psychiatric Association, 2013)

Although there is no global consensus on the prevalence of attention-deficit hyperactivity disorder (ADHD), meta analyses have estimated the worldwide prevalence at between 5.29% and 7.1% in children and adolescents, and at 3.4% (range 1.2–7.3%) in adults (Fayyad et al., 2007).

**Bipolar Disorder**

Bipolar disorder is a mood disorder with a broad spectrum of symptoms, but is marked by episodic periods of depression and mania. In addition to changes in mood, the disorder also includes fluctuations in energy, self-perception, speed of cognition, and difficulties with impulse control. Manic periods can includes symptoms such as restlessness, increased energy, talkativeness, recklessness, euphoria, spending sprees, and risky sexual behavior. Depressive periods can include irritation, confusion, anger, feelings of being trapped, significantly depressed mood, and sometimes suicidal ideation (Federman, 2011).

The rate of Bipolar I Disorder is approximately equal in both males and females, but gender does appear to be related to the number and type of episodes (manic episodes are more common in men and outnumber the depressive episodes, while major depressive episodes are more common in women and outnumber the manic episodes). The 12-month prevalence rate for Bipolar I and II disorders is 2.6%. (Kessler et al., 2005b)

**Borderline Personality Disorder**

"Borderline personality disorder (BPD) is a serious mental disorder marked by a pattern of ongoing instability in moods, behavior, self-image, and functioning. These experiences often result in impulsive actions and unstable relationships. A person with BPD may experience intense episodes of anger, depression, and anxiety that may last from only a few hours to days. Some people with BPD also have high rates of co-occurring mental disorders, such as mood disorders, anxiety disorders, and eating disorders, along with substance abuse, self-harm, suicidal thinking and behaviors, and suicide. While mental health experts now generally agree that the label "borderline personality disorder" is very misleading, a more accurate term does not exist yet." (NIMH, 2016)

Text retrieved from: https://www.nimh.nih.gov/health/topics/borderline-personality-disorder/index.shtml

**Bulimia Nervosa**

**"**People with bulimia nervosa have recurrent and frequent episodes of eating unusually large amounts of food and feeling a lack of control over these episodes. This binge-eating is followed by behavior that compensates for the overeating such as forced vomiting, excessive use of laxatives or diuretics, fasting, excessive exercise, or a combination of these behaviors. Unlike anorexia nervosa, people with bulimia nervosa usually maintain what is considered a healthy or relatively normal weight." (NIMH, 2016)

Text retrieved from: https://www.nimh.nih.gov/health/topics/eating-disorders/index.shtml?utm_source=rss&utm_medium=rss

**Eating Disorders**

**"**There is a commonly held view that eating disorders are a lifestyle choice. Eating disorders are actually serious and often fatal illnesses that cause severe disturbances to a person's eating behaviors. Obsessions with food, body weight, and shape may also signal an eating disorder. Common eating disorders include anorexia nervosa, bulimia nervosa, and binge-eating disorder." (NIMH, 2016)

Text retrieved from: https://www.nimh.nih.gov/health/topics/eating-disorders/index.shtml?utm_source=rss&utm_medium=rss

**Eating Disorder Not Otherwise Specified (EDNOS)**

This psychiatric diagnosis is applied when an individual's behaviors related to food or eating cause significant distress but do not fit neatly within the strict

criteria for anorexia, bulimia, avoidance/restrictive food intake disorder (ARFID) or binge eating disorder. (American Psychiatric Association, 1994)

Note that as of the publication of DSM-5 in 2013, EDNOS was revised, refined, and renamed "Other Specified Feeding and Eating Disorder" (OSFED). That said, participants in this study who report a former diagnosis of "EDNOS" were given this diagnosis prior to 2013.

**Generalized Anxiety Disorder (GAD)**

GAD is a psychiatric condition marked by the presence of excessive worry about a variety of topics, events, or activities. This worry occurs more often than not for at least 6 months, is difficult to control, and is associated with various physical and/or cognitive symptoms. The anxiety, worry, or associated symptoms interfere with daily activities and responsibilities and may cause problems in relationships, at school, work, or in various other life domains. (American Psychiatric Association, 2013).

The 12-month prevalence rate for GAD is 3.1%. (Kessler et al., 2005b)

**Major Depressive Disorder (MDD)**

MDD is a psychiatric condition that affects emotions, cognition, and behavior. It entails persistent feelings of sadness and loss of interest in previously enjoyed activities, and can lead to a variety of emotional and physical problems. It is fairly common and is often a chronic and episodic condition requiring long-term treatment. MDD is more common in women than in men. Its general 12-month prevalence rate across both sexes is 6.7%% (Kessler et al., 2005b)

**Obsessive Compulsive Disorder (OCD)**

Obsessive-Compulsive Disorder (OCD) is a common, chronic and long-lasting disorder in which a person has uncontrollable, reoccurring thoughts (*obsessions*) and behaviors (*compulsions*) that he or she feels the urge to repeat over and over. (NIMH, 2016). Twelve-month prevalence rate is 1.0% (Kessler et al., 2005b)

**Panic Disorder**

> "People with panic disorder have recurrent unexpected panic attacks, which are sudden periods of intense fear that may include palpitations, pounding heart, or accelerated heart rate; sweating; trembling or shaking; sensations of shortness of breath, smothering, or choking; and feeling of impending doom. Panic disorder symptoms include: sudden and repeated attacks of intense fear**, f**eelings of being out of control during a panic attack**;** intense worries about when the next attack will happen; and fear or avoidance of places where panic attacks have occurred in the past" (NIMH, 2016).
>
> Text retrieved from: http://www.nimh.nih.gov/health/topics/anxiety-disorders/index.shtml

The 12-month prevalence rate is 2.7% (Kessler et al., 2005b)

**Psychotic Disorder**

Psychotic disorders are severe mental disorders that cause abnormal thinking and perceptions. People with psychoses lose touch with reality, and two of the primary symptoms are delusions and hallucinations. Delusions are false beliefs (such as thinking that someone is plotting against you) and hallucinations are false perceptions (such as hearing, seeing, or feeling something that is not there). (NIMH, 2016). The lifetime prevalence of all psychotic disorders is approximately 3.06%. Lifetime prevalence for schizophrenia, the most common psychotic disorder, is 0.87% (Perala et al., 2007)

**Schizophrenia**

"Schizophrenia is a chronic and severe mental disorder that affects how a person thinks, feels, and behaves. People with schizophrenia may appear as if they have lost touch with reality. Although schizophrenia is not as common as other mental disorders, the symptoms can be very disabling. Symptoms of schizophrenia usually start between ages 16 and 30. In rare cases, children have schizophrenia too.

"The symptoms of schizophrenia fall into three categories: positive, negative, and cognitive. **'**Positive' symptoms are psychotic behaviors not generally seen in healthy people. People with positive symptoms may 'lose touch' with some aspects of reality. Symptoms include: hallucinations, delusions, thought disorders (unusual or dysfunctional ways of thinking), and movement disorders (agitated body movements). 'Negative' symptoms are associated with disruptions to normal emotions and behaviors. Symptoms include: 'flat affect' (reduced expression of emotions via facial expression or voice tone), reduced feelings of pleasure in everyday life, difficulty beginning and sustaining activities, and reduced speaking. For some patients, the cognitive symptoms of schizophrenia are subtle, but for others, they are more severe and patients may notice changes in their memory or other aspects of thinking. Symptoms include: poor executive functioning, trouble focusing or paying attention, and problems with working memory." (NIMH 2016).

Text retrieved from:
http://www.nimh.nih.gov/health/topics/schizophrenia/index.shtml

APPENDIX I
Text for survey recruitment via social media

**University of Pennsylvania IRB**
**Confirmation #: bgbggjdh**
**Protocol Number: 820944**
**Protocol Title:** *College in Mind: A mixed-methods study of how emerging adults with psychiatric disabilities prepare for and transition to college*

Text for recruitment of survey respondents via social media:

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The University of Pennsylvania's Graduate School of Education is conducting a research study of young adults with psychiatric disabilities who are going to college, and we would love to have your input!

- If you are between the ages of 18-25,
- you have a current diagnosis of a mood, anxiety, or psychotic disorder (e.g. major depression, bipolar, generalized anxiety disorder, obsessive-compulsive disorder, schizophrenia, or schizoaffective disorder),
- you received your diagnosis while in elementary, middle, or high school,
- and you will be a full-time or part-time college student in the U.S. in Fall 2015

You are invited to participate in an anonymous online survey about your experiences in school while managing serious mental illness.

Total time to complete the survey is approximately 35-45 minutes, and respondents can opt to enter a raffle to win one of three $100 gift cards.

To read more about the study and/or to access and complete the survey, please go here:
https://upenn.co1.qualtrics.com/SE/?SID=SV_1BnG2d6e3vXIv6l

You can also contact the primary study contact, Laura C. Murray, at the following email address if you have questions:
lamurray@gse.upenn.edu

Thank you!

APPENDIX J
Consent Form for Anonymous Online Survey

**University of Pennsylvania IRB**
**Confirmation #: bgbggjdh**
**Protocol Number: 820944**
**Protocol Title:** *College in Mind: A mixed-methods study of how merging adults with psychiatric disabilities prepare for and transition to college*

Consent Form for Online Survey (appears on first page of online survey, which can be accessed here: https://upenn.co1.qualtrics.com/SE/?SID=SV_1BnG2d6e3vXIv6l

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***College in Mind: How young adults with mental illness prepare for and transition to college***

**General Information about this study**:

Thank you for your interest in our survey! The survey is part of a study about young adults, ages 18-25, who have a serious mental illness and who are college students.

If you are between the ages of 18 and 25; you have a mood, anxiety, or psychotic disorder; you were diagnosed prior to entering college; and you will be enrolled as a part-time or full-time college student in the United States in Fall, 2015, you are welcome to complete the survey. We'd love to learn about your experiences planning for and transitioning into college.

**How long will this survey take to complete?**

This survey has several different sections and will ask you about your general background, your mental health history, your experiences in high school, your choices related to whether to tell people at school about your mental illness, and your experiences in college related to having a mental illness. It will take approximately 35-45 minutes to complete all of the sections.

**Confidentiality:**

The survey is entirely anonymous and confidential. Your identity will be protected.

**Financial Information:**

Your participation in this survey will involve no cost to you. At the end of the survey, and as a thank you for your time, you can opt to be entered into a raffle to win one of three $100 Amazon gift cards. You would provide an email address, and in January 2016, after the survey closes, three winners will be drawn from the list of emails. I will contact the winners and make sure that you receive your prizes.

**Contact Persons:**

If you have any questions about this study please contact me, Laura Murray (co-investigator and study contact) at:
phone (310) 463-9692 or email: lamurray@gse.upenn.edu

If you have any questions about your rights as a research subject, you may call the Office of Regulatory Affairs, Institutional Review Board at University of Pennsylvania: (215) 898-2614.

**Consent:**

If you agree to participate in the survey, just click the "I CONSENT" button at the bottom of the page, and you can proceed with the survey.

THANK YOU!

**College in Mind: How young adults with mental illness prepare for and transition to college**

**I. General Information about this study:**
Thank you for your interest in our survey! The survey is part of a study about young adults, ages 18-25, who have a serious mental illness and who are college students.

**Is this survey for me?** If you are between the ages of 18 and 25; you have a mood, anxiety, or psychotic disorder; your mental health challenges began before college entrance, and you are enrolled as a part-time or full-time college student in the United States in Fall, 2015, you are welcome to complete the survey. We'd love to learn about your experiences planning for and transitioning into college.

**How long will this survey take to complete?** This survey has several different sections and will ask you about your general background, your mental health history, your experiences in high school, your choices related to whether to tell people at school about your mental illness, and your experiences in college related to having a mental illness. The survey is entirely anonymous and confidential. It should take between 35 and 45 minutes to complete all of the sections.

If you would like to take a break and come back to complete the survey later, you can. Your answers will be automatically saved and stored for up to one week. Just return to the survey on the same internet browser and computer that you started on.

**Confidentiality:** This survey is entirely anonymous and your identity will be protected.

**Financial Information:** Your participation in this survey will involve no cost to you. At the end of the survey, and as a thank you for your time, you can opt to be entered into a raffle to win one of three $100 Amazon gift cards. You would provide an email address, and in January 2016, after the survey closes, three winners will be drawn from the list of emails. I will contact the winners and make sure that you receive your prizes.

**Contact Persons:** If you have any questions about this study please contact Laura Murray at: phone (310) 463-9692 or email: lamurray@gse.upenn.edu If you have any questions about your rights as a research participant, you may call the Office of Regulatory Affairs, Institutional Review Board at University of Pennsylvania: (215) 898-2614.

**Consent:** If you agree to participate in the survey, just click the "I consent" button at the bottom of the page, and you can proceed with the survey. THANK YOU!

- ❍ I consent to participate in this anonymous survey (1)
- ❍ I do not consent to participate in this anonymous survey (2)

If “I do not consent ” Is Selected, Then Skip To End of Survey

Thank you very much for agreeing to complete our survey. Before you start, we wanted to let you know that we use the term “mental illness” throughout the survey, but please think of this in whatever way makes the most sense for you. Some people prefer the terms “serious mental health condition,” or “psychiatric disability,” while other people prefer naming a specific disorder, like “bipolar disorder.” Still other people don’t like labels and don’t use them at all. We understand that there’s no perfect solution, and we’ve chosen “mental illness” as a way to represent these complex meanings efficiently just for the purposes of this survey. Thanks for understanding!

**II. This section of the survey asks some questions about your background**.

Q2-01 What is your age?
- ❍ 17 or younger (1)
- ❍ 18 (2)
- ❍ 19 (3)
- ❍ 20 (4)
- ❍ 21 (5)
- ❍ 22 (6)
- ❍ 23 (7)
- ❍ 24 (8)
- ❍ 25 (9)
- ❍ 26 or older (10)

If “17 or younger” Is Selected, Then Skip To End of Survey. If “26 or older” Is Selected, Then Skip To End of Survey

Q2-02 Are you currently a college student or a Spring 2015 graduate?
- ❍ Yes (1)
- ❍ No (2)

If “No” Is Selected, Then Skip To End of Survey

Q2-03 What is your gender?
- ❍ Male (1)
- ❍ Female (2)
- ❍ Transgender (3)
- ❍ Other (4)

Q2-04 What is your race/ethnicity?

- African-American or Black (1)
- Asian (2)
- Caucasian/ White (3)
- Latina/o or Hispanic (4)
- Native American or Alaskan Native (5)
- Native Hawaiian or Pacific Islander (6)
- Multi-racial (7)
- Other (8)
- I prefer not to respond (9)

Q2-05 Are you an international student or foreign national?

- Yes (1)
- No (2)

Answer If “Are you an international student or foreign national? Yes” Is Selected

Q2-06 What country are you from?

Q2-07 What is the highest level of education completed by either of your parents?

- Did not finish high school (1)
- High school diploma or GED (2)
- Attended college but did not complete a degree (3)
- Associate's degree (A.A., A.S., etc.) (4)
- Bachelor's degree (B.A., B.S., etc.) (5)
- Master's degree (M.A., M.S., etc.) (6)
- Doctoral or Professional degree (Ph.D., J.D., M.D., etc.) (7)
- Don't Know (8)

---

**III. The next section of the survey is about your mental illness history.**

Q3-01 What is your current psychiatric diagnosis? (Please check all that apply.)
- ❑ Anorexia Nervosa (1)
- ❑ Attention Deficit - Hyperactivity disorder (ADHD) (2)
- ❑ Autism spectrum (3)
- ❑ Bipolar disorder I (4)
- ❑ Bipolar disorder II (5)
- ❑ Borderline personality disorder (6)
- ❑ Bulimia Nervosa (7)
- ❑ Eating Disorder Not Otherwise Specified (EDNOS) (8)
- ❑ Generalized anxiety disorder (9)
- ❑ Panic disorder (10)
- ❑ Major Depressive disorder (11)
- ❑ Obsessive-compulsive disorder (OCD) (12)
- ❑ Post-traumatic stress disorder (PTSD) (13)
- ❑ Psychotic disorder not otherwise specified (14)
- ❑ Schizo-affective disorder (15)
- ❑ Schizophrenia (16)
- ❑ Substance abuse (17)
- ❑ Other (18)

Answer If “What is your current psychiatric diagnosis? (Please check all that apply.) Other” Is Selected
Q3-02 If you checked "Other" above, please write in additional diagnoses here

Q3-03 Age when you first started experiencing mental health problems (please write in the number, below):

Q3-04 Grade in school when you first started experiencing mental health problems:
- ❍ before 6th grade (1)
- ❍ between 6th and 8th grades (2)
- ❍ 9th grade (3)
- ❍ 10th grade (4)
- ❍ 11th grade (5)
- ❍ 12th grade (6)
- ❍ after high school completion (7)
- ❍ I didn't start experiencing mental health problems until after I started college. (8)

Q3-05 Age when you were first formally diagnosed by a mental health professional (please write in the number, below):

Q3-06 Grade in school when you were first formally diagnosed by a mental health professional:

- ❍ before 6th grade (1)
- ❍ some time between 6th and 8th grade (2)
- ❍ 9th grade (3)
- ❍ 10th grade (4)
- ❍ 11th grade (5)
- ❍ 12th grade (6)
- ❍ after completing high school (7)
- ❍ I wasn't diagnosed until after I started college (8)

Q3-07 If your diagnosis has changed over time, how old were you when you received your current diagnosis? (Please write in the number, below):

Q3-08 Types of mental health professionals you saw prior to beginning college (please check all that apply):

- ❑ Psychiatrist (1)
- ❑ Psychologist (outside of school) (2)
- ❑ School psychologist (3)
- ❑ School counselor (4)
- ❑ School social worker (5)
- ❑ Clinical Social worker (outside of school) (6)
- ❑ Addictions counselor (7)
- ❑ None (Did not see a mental health professional before college) (8)
- ❑ Other (9)

Q3-09 If you checked "Other" above, please describe the additional type(s) of mental health professionals you have seen since you were first diagnosed here:

Q3-10 Types of treatments you accessed prior to beginning college (please check all that apply):

- ❑ Psychiatric medication(s) (1)
- ❑ Cognitive-Behavioral therapy (2)
- ❑ Dialectical Behavioral therapy (3)
- ❑ Other types of "talk therapy" (4)
- ❑ In-patient Hospitalization (5)
- ❑ Partial Hospitalization (6)
- ❑ Residential treatment for mental illness (7)
- ❑ Residential drug or alcohol rehabilitation (8)
- ❑ None (Did not access any treatment for my mental illness prior to beginning college) (9)
- ❑ Other (10)

Answer If “Types of treatments you accessed prior to beginning college (please check all that apply): Other” Is Selected

Q3-11 If you checked "Other" above, please describe the additional types of treatments you accessed prior to beginning college:

Q3-12 Types of non-medical services, organizations, or other supports you accessed prior to coming to college (please check all that apply):

- ❑ Active Minds (1)
- ❑ community "club house" for people with mental illness (2)
- ❑ Let's Erase the Stigma (3)
- ❑ National Alliance on Mental Illness (NAMI) programs (4)
- ❑ NAMI on Campus (6)
- ❑ Social Media Sites related to youth mental health (5)
- ❑ Supported Education program for college students with mental illness (7)
- ❑ Youth MOVE (8)
- ❑ None (Have never accessed any non-medical services, organizations, or other supports) (9)
- ❑ Other (10)

Answer If “Types of non-medical services, organizations, or other supports you have accessed since you were first diagnosed (please check all that apply): Social Media Sites related to youth mental health” Is Selected

Q3-13 If you checked "Social Media Sites related to youth mental health" above, please list your favorite ones here

Answer If “Types of non-medical services, organizations, or other supports you have accessed since you were first diagnosed (please check all that apply): Other types of supports” Is Selected

Q3-14 And if you checked "Other" above, please list these here

Q3-15 Types of mental health professionals you have seen since beginning college (please check all that apply):

- ❑ Psychiatrist (off-campus and outside of school) (1)
- ❑ Psychiatrist (on-campus) (2)
- ❑ Psychologist (off-campus and outside of school) (3)
- ❑ Psychologist (on-campus) (4)
- ❑ Psychiatric Nurse Practitioner (off-campus and outside of school) (5)
- ❑ Psychiatric Nurse Practitioner (on-campus) (9)
- ❑ Counselor (off-campus and outside of school) (6)
- ❑ Counselor (on-campus) (7)
- ❑ Social Worker (off-campus and outside of school) (8)
- ❑ Social Worker (on-campus) (14)
- ❑ Addictions counselor (off-campus and outside of school) (15)
- ❑ Addictions counselor (on-campus) (16)
- ❑ No one (Have not seen a mental health professional since beginning college) (17)
- ❑ Other (18)

Answer If “Types of mental health professionals you have seen since you were first diagnosed (please check all that apply): Other” Is Selected

Q3-16 If you checked "Other" above, please describe the additional type(s) of mental health professionals you have seen since beginning college here:

Q3-17 Types of treatments you have accessed since beginning college (please check all that apply):

- ❑ Psychiatric medication(s) (1)
- ❑ Cognitive Behavioral therapy (2)
- ❑ Dialectical Behavior therapy (8)
- ❑ Other types of "talk therapy" (3)
- ❑ In-patient Hospitalization (4)
- ❑ Partial Hospitalization (9)
- ❑ Residential drug or alcohol rehabilitation (5)
- ❑ Residential treatment for mental illness (10)
- ❑ None (Have not accessed any treatments since beginning college) (6)
- ❑ Other (7)

Answer If “Types of treatments you have accessed in the last year (please check all that apply): Other” Is Selected

Q3-18 If you checked "Other" above, please describe the additional types of treatments you have accessed since beginning college.

Q3-19 Types of non-medical services, organizations, or other supports you have accessed since beginning college (please check all that apply):

- ❑ Active Minds (1)
- ❑ Community "club house" for people with mental illness (2)
- ❑ Let's Erase the Stigma (3)
- ❑ National Alliance on Mental Illness (NAMI) (4)
- ❑ NAMI on Campus (5)
- ❑ Supported Education program for college students with mental illness (7)
- ❑ Social media sites related to young adult mental health (8)
- ❑ Youth Move (9)
- ❑ None (Have not accessed any non-medical services, organization, or other supports since beginning college) (10)
- ❑ Other types of supports (12)

Answer If “Types of non-medical services, organizations, or other supports you have accessed since beginning... Social media sites related to young adult mental health” Is Selected

Q3-20 Please list your favorite "Social media sites related to young adult mental health" here

Answer If “Types of non-medical services, organizations, or other supports you have accessed since beginning... Other types of supports” Is Selected

Q3-21 Please list your "Other types of supports" here:

Q3-22 Have you ever been hospitalized for your mental illness while in middle school or high school?

- ❍ Yes (1)
- ❍ No (2)

Answer If “Have you ever been hospitalized for your mental illness? Yes” Is Selected

Q3-23 How many separate times were you hospitalized while in middle school or high school? Please write in the number below.

Answer If “Have you ever been hospitalized for your mental illness? Yes” Is Selected

Q3-24 How many total days did you spend in the hospital (combining all of your hospitalizations together) in middle school and high school? Please write in your best estimate below.

Answer If “Have you ever been hospitalized for your mental illness? Yes” Is Selected

Q3-25 Did these hospital stays keep you out of middle school or high school for any amount of time?

- ❍ Yes (1)
- ❍ No (2)

Answer If “Did these hospital stays keep you out of middle school or high school for any amount of time? Yes” Is Selected

Q3-26 Please estimate the number of days you were out of middle school or high school due to hospital stays and please write in the number below.

Q3-27 Have you ever been hospitalized for your mental illness while in college?

- ❍ Yes (1)
- ❍ No (2)

Answer If “Have you ever been hospitalized for your mental illness while in college? Yes” Is Selected

Q3-28 How many separate times were you hospitalized while in college? Please write in the number below.

Answer If “Have you ever been hospitalized for your mental illness while in college? Yes” Is Selected

Q3-29 How many total days did you spend in the hospital (combining all of your hospitalizations together) while a college student? Please write in your best estimate below.

Answer If “Have you ever been hospitalized for your mental illness while in college? Yes” Is Selected

Q3-30 Did these hospital stays keep you out of college for any amount of time?

- ❍ Yes (1)
- ❍ No (2)

Answer If “Did these hospital stays keep you out of college for any amount of time? Yes” Is Selected

Q3-31 Please estimate the number of days you were out of college due to hospital stays and please write in the number below.

Q3-32 Have you ever spent time in a residential treatment facility (not a hospital) while in middle school and/or high school because of your mental illness?

- ❍ Yes (1)
- ❍ No (2)

Answer If “Have you ever spent time in a residential treatment facility (not a hospital) because your mental illness ? Yes” Is Selected

Q3-33 How many separate times did you go into residential treatment (not a hospital) in middle school and/or high school? Please write in the number below.

Answer If “Have you ever spent time in a residential treatment facility (not a hospital) because your mental illness ? Yes” Is Selected

Q3-34 Please estimate how many total days you were in residential treatment (not a hospital) in middle school and/or high school. Write in the number below.

Answer If “Have you ever spent time in a residential treatment facility (not a hospital) because your mental illness ? Yes” Is Selected

Q3-35 Did this residential treatment for your mental illness keep you out of middle school and/or high school for any amount of time?

- ❍ Yes (1)
- ❍ No (2)

Answer If “Did this residential treatment for your mental illness keep you out of school for a period of time? Yes” Is Selected

Q3-36 Please estimate how many total days you spent out of middle school and/or high school (combining all of your residential treatment stays together). Write in the number below.

Q3-37 Have you ever spent time in a residential treatment facility (not a hospital) while in college because of your mental illness ?

- ❍ Yes (1)
- ❍ No (2)

Answer If “Have you ever spent time in a residential treatment facility (not a hospital) while in college because of your mental illness? Yes” Is Selected

Q3-38 How many separate times did you go into residential treatment while in college? Please write in the number below.

Answer If “Have you ever spent time in a residential treatment facility (not a hospital) while in college because of your mental illness? Yes” Is Selected

Q3-39 Please estimate how many total days you were in residential treatment while in college. Write in the number below.

Answer If “Have you ever spent time in a residential treatment facility (not a hospital) because of your men... Yes” Is Selected

Q3-40 Did this residential treatment for your mental illness keep you out of college for any amount of time?

- ❍ Yes (1)
- ❍ No (2)

Answer If “Did this residential treatment for your mental illness keep you out of college for any amount of time? Yes” Is Selected

Q3-41 Please estimate how many total days you spent out of college (combining all of your residential stays together). Write in the number below.

_____

**IV. The next section of the survey is about your high school experience.**

Q4-01 The type of high school you attended was (please select all that apply).

- ❑ Urban public high school (1)
- ❑ Urban charter high school (2)
- ❑ Urban private high school (21)
- ❑ Suburban public high school (10)
- ❑ Suburban charter high school (11)
- ❑ Suburban private high school (22)
- ❑ Rural public high school (12)
- ❑ Rural charter high school (13)
- ❑ Rural private high school (23)
- ❑ Boarding school (24)
- ❑ Religiously affiliated (5)
- ❑ Therapeutic school for students with social/emotional/behavioral challenges (day school) (6)
- ❑ Therapeutic school for students with social/emotional/behavioral challenges (residential school) (7)
- ❑ Home-schooled (8)
- ❑ Other (9)

Answer If “Type of high school you attended (please select all that apply). Other” Is Selected

Q4-02 Please describe the type of high school(s) you attended here.

Q4-03 Your approximate high school grade point average (GPA), on a 4 point scale:

- ❍ 1.0 (1)
- ❍ 1.5 (2)
- ❍ 2.0 (3)
- ❍ 2.5 (4)
- ❍ 3.0 (5)
- ❍ 3.5 (6)
- ❍ 4.0 (7)
- ❍ 4.5 (8)
- ❍ 5 (9)

Q4-04 Did you complete high school and earn a diploma?
- ❍ Yes (1)
- ❍ No (2)

Answer If "Did you complete high school and earn a diploma? Yes" Is Selected

Q4-05 What year did you graduate from high school?

Answer If "Did you complete high school and earn a diploma? No" Is Selected

Q4-06 Did you leave high school and earn a GED?
- ❍ Yes (1)
- ❍ No (2)

Answer If "Did you leave high school and earn a GED? Yes" Is Selected

Q4-07 How many years of high school did you complete before leaving school?

Answer If "Did you leave high school and earn a GED? Yes" Is Selected

Q4-08 How old were you when you left traditional high school?

Answer If "Did you leave high school and earn a GED? Yes" Is Selected

Q4-09 How old were you when you completed a GED?

Q4-10 Did you participate in extra-curricular activities in high school?
- ❍ Yes (1)
- ❍ No (2)

Answer If "Did you participate in extra-curricular activities in high school? Yes" Is Selected

Q4-11 Please check all of the extra-curriculars you participated in when in high school:
- ❑ Band, Orchestra, Music (1)
- ❑ Drama club, Theater, School plays (2)
- ❑ Sports (3)
- ❑ Student Government (4)
- ❑ Yearbook (5)
- ❑ Other (6)

Answer If "Please check all of the extra-curriculars you participated in when in high school: Sports" Is Selected

Q4-12 Please list the sport(s) that you played in high school here:

Answer If "Please check all of the extra-curriculars you participated in when in high school: Other" Is Selected

Q4-13 Please describe the other school-based extra-curricular(s) that you participated in while in high school here.

Q4-14 Did your high school have a mental health awareness, education, or advocacy club?

- ❍ Yes (1)
- ❍ No (2)
- ❍ I don't know (3)

Answer If “Did your high school have a student-run mental health awareness or advocacy club? Yes” Is Selected

Q4-15 Were you a member of this high school mental health awareness, education, or advocacy club?

- ❍ Yes (1)
- ❍ No (2)

Answer If “Did your high school have a mental health awareness, education, or advocacy club? Yes” Is Selected

Q4-16 What was the name of your high school mental health awareness, education, or advocacy club?

- ❍ Active Minds (1)
- ❍ NAMI on Campus (2)
- ❍ Let's Erase the Stigma (LETS) (3)
- ❍ Other (4)
- ❍ I don't know (5)

Answer If “What was the name of your high school mental health awareness, education, or advocacy club? Other” Is Selected

Q4-17 Please type in the name of your high school mental health awareness, education, or advocacy club here:

Q4-18 Did you work for pay during the school year while in high school?

- ❍ Yes (1)
- ❍ No (2)

Answer If “Did you work for pay while in high school? Yes” Is Selected

Q4-19 How many hours per week did you work for pay during the school year while in high school? (Please write in your response, below.)

Answer If “Did you work for pay while in high school? Yes” Is Selected

Q4-20 What type of job did you have? Please describe in the space below:

Q4-21 Did you do volunteer work during the school year while in high school?

- ❍ Yes (1)
- ❍ No (2)

Answer If "Did you do volunteer work while in high school? Yes" Is Selected

Q4-22 How many hours per week did you do volunteer work during the school year while in high school? (Please write in your response, below.

Answer If "Did you do volunteer work while in high school? Yes" Is Selected

Q4-23 What type of volunteer work did you do? Please describe in the space below:

Q4-24 Did you have an IEP ("Individual Education Plan") in high school?

- ❍ Yes (1)
- ❍ No (2)
- ❍ Not sure (3)

Answer If "Did you have an IEP ("Individual Education Plan") in high school? "Yes" Is Selected

Q4-25 During which grades did you have an IEP in high school? (Please select all grades that are applicable.)

- ❑ 9th grade (1)
- ❑ 10th grade (2)
- ❑ 11th grade (3)
- ❑ 12th grade (4)
- ❑ Can't remember (5)

Answer If "Did you have an IEP ("Individual Education Plan") in high school? Yes" Is Selected

Q4-26 Did you participate in "post-secondary transition meetings" with staff at your school to talk about your plans and goals for after high school?

- ❍ Yes (1)
- ❍ No (2)
- ❍ Can't remember (3)

Answer If "Did you participate in "post-secondary transition meetings" with staff at your school to talk about your plans and goals for after high school? Yes" Is Selected

Q4-27 Did you discuss college planning in any of these meetings?

- ❍ Yes (1)
- ❍ No (2)
- ❍ Can't remember (3)

**For the questions below, please mark whether you *Strongly Disagree*, *Disagree*, are *Not Sure*, *Agree,* or *Strongly Agree*.**

4-28 I spent most of my high school days in classes with peers who did not have a mental illness or "serious emotional disturbance."

- Strongly Disagree (1)
- Disagree (2)
- Not sure (3)
- Agree (4)
- Strongly Agree (5)

Q4-29 I spent most of my high school days in classes with peers who also had a mental illness or "serious emotional disturbance.".

- Strongly Disagree (1)
- Disagree (2)
- Not sure (3)
- Agree (4)
- Strongly Agree (5)

Q4-30 In high school, I had at least one good friend around my age that I trusted and could talk to if I needed support.

- Strongly Disagree (1)
- Disagree (2)
- Not sure (3)
- Agree (4)
- Strongly Agree (5)

Answer If “In high school, I had at least one good friend that I trusted and could talk to if I needed sup... Agree” Is Selected Or “In high school, I had at least one good friend that I trusted and could talk to if I needed sup... Strongly Agree” Is Selected

Q4-31 This friend also had a mental illness.

- Yes (1)
- No (2)
- Don't know (3)

Q4-32 In high school, I had at least one adult in my life, outside of my immediate family, that I trusted and could talk to if I needed support.

- Strongly Disagree (1)
- Disagree (2)
- Not sure (3)
- Agree (4)
- Strongly Agree (5)

Q4-33 While I was in high school, I was satisfied with my social life.
- ❍ Strongly Disagree (1)
- ❍ Disagree (2)
- ❍ Not sure (3)
- ❍ Agree (4)
- ❍ Strongly Agree (5)

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**V. This section of the survey is about whether and how you chose to tell people about your mental illness when you were in High School.**

**We use the word "disclose," below, to mean if you told someone about your mental health challenges.**

Q5-01 Please select the statement, below, that is most accurate for you:
- ❍ In high school, I disclosed to most of the people in my daily life (1)
- ❍ In high school, I selectively disclosed to certain people in my daily life (2)
- ❍ In high school, I hardly disclosed to anyone in my daily life (3)
- ❍ In high school, I did not disclose to anyone (4)
- ❍ In high school, disclosure was not an issue because I didn't experience any mental health challenges until after completing high school. (5)

If In “high school, I did not disclose to anyone” Is Selected, Then Skip To “What are the reasons that you decided not to disclose” and if “In high school, disclosure was not an issue…” Is Selected, Then Skip To End of Block

Q5-02 I disclosed my mental illness to certain teachers or other adults at my high school.
- ❍ Yes (1)
- ❍ No (2)

**Please complete the following questions by marking whether you *Strongly Disagree, Disagree, Neither Agree nor Disagree, Agree*, or *Strongly Agree*.**

Answer If “I spoke about my mental illness with teachers or other adults at my high school. Yes” Is Selected

Q5-03 I disclosed some of my mental illness experience to teachers or other adults at my high school in order to access formal services and academic accommodations.
- ❍ Strongly Disagree (1)
- ❍ Disagree (2)
- ❍ Not sure (3)
- ❍ Agree (4)
- ❍ Strongly Agree (5)

Answer If “I spoke about my mental illness with teachers or other adults at my high school. Yes” Is Selected

Q5-04 I disclosed some of my mental illness experience to teachers and other adults at my high school so they could help me with schoolwork if I needed support or had to miss school because of my illness.

- ❍ Strongly Disagree (1)
- ❍ Disagree (2)
- ❍ Not sure (3)
- ❍ Agree (4)
- ❍ Strongly Agree (5)

Answer “If I spoke about my mental illness with certain teachers or other adults at my high school. Yes” Is Selected

Q5-05 I disclosed some of my mental illness experience to teachers and other adults at my high school so they could understand me better.

- ❍ Strongly Disagree (1)
- ❍ Disagree (2)
- ❍ Not sure (3)
- ❍ Agree (4)
- ❍ Strongly Agree (5)

Answer If “I spoke about my mental illness with certain teachers or other adults at my high school. Yes” Is Selected

Q5-06 When I disclosed some of my mental illness experience in high school, teachers and school staff listened respectfully.

- ❍ Strongly Disagree (1)
- ❍ Disagree (2)
- ❍ Not sure (3)
- ❍ Agree (4)
- ❍ Strongly Agree (5)

Answer If “I spoke about my mental illness with certain teachers or other adults at my high school. Yes” Is Selected

Q5-07 When I disclosed some of my mental illness experience in high school, teachers and school staff understood me.

- ❍ Strongly Disagree (1)
- ❍ Disagree (2)
- ❍ Not sure (3)
- ❍ Agree (4)
- ❍ Strongly Agree (5)

Answer If “I spoke about my mental illness with certain teachers or other adults at my high school. Yes” Is Selected

Q5-08 When I disclosed some of my mental illness experience in high school, teachers and school staff accepted me.

- ❍ Strongly Disagree (1)
- ❍ Disagree (2)
- ❍ Not sure (3)
- ❍ Agree (4)
- ❍ Strongly Agree (5)

Answer If “I spoke about my mental illness with certain teachers or other adults at my high school. Yes” Is Selected

Q5-09 When I disclosed some of my mental illness experience in high school, teachers and school staff seemed uncomfortable.

- ❍ Strongly Disagree (1)
- ❍ Disagree (2)
- ❍ Not sure (3)
- ❍ Agree (4)
- ❍ Strongly Agree (5)

Answer If “I spoke about my mental illness with certain teachers or other adults at my high school. Yes” Is Selected

Q5-10 When I disclosed some of my mental illness experience in high school, teachers and school staff treated me worse afterwards.

- ❍ Strongly Disagree (1)
- ❍ Disagree (2)
- ❍ Not sure (3)
- ❍ Agree (4)
- ❍ Strongly Agree (5)

Answer If “I spoke about my mental illness with certain teachers or other adults at my high school. Yes” Is Selected

Q5-11 When I disclosed some of my mental illness experience in high school, teachers and school staff treated me better afterwards.

- ❍ Strongly Disagree (1)
- ❍ Disagree (2)
- ❍ Not sure (3)
- ❍ Agree (4)
- ❍ Strongly Agree (5)

Answer If “I spoke about my mental illness with certain teachers or other adults at my high school.  Yes” Is Selected

Q5-12 When I disclosed some of my mental illness experience in high school, teachers and school staff treated me the same afterwards.

- ❍ Strongly Disagree (1)
- ❍ Disagree (2)
- ❍ Not sure (3)
- ❍ Agree (4)
- ❍ Strongly Agree (5)

Q5-13 I disclosed my mental illness to classmates at my high school.

- ❍ Yes (1)
- ❍ No (2)

Answer If “I disclosed my mental illness to classmates at my high school.  Yes” Is Selected

Q5-14 When I was in high school, I disclosed some of my mental illness experience to large group of peers  at school (e.g. in a class, assembly, or other event).

- ❍ Yes (1)
- ❍ No (2)

Answer If “I disclosed my mental illness to classmates at my high school.  Yes” Is Selected

Q5-15 When I was in high school, I only disclosed some of my mental illness experience to certain friends and classmates.

- ❍ Yes (1)
- ❍ No (2)

Please complete the following questions by marking whether you Strongly Disagree, Disagree, are Not Sure, Agree, or Strongly Agree.

Answer If “I disclosed my mental illness to classmates at my high school.  Yes” Is Selected

Q5-16 I disclosed some of my mental illness experience at my high school so peers could help me with schoolwork if I needed support or had to miss school because of my illness.

- ❍ Strongly Disagree (1)
- ❍ Disagree (2)
- ❍ Not sure (3)
- ❍ Agree (4)
- ❍ Strongly Agree (5)

Answer If “I disclosed my mental illness to classmates at my high school.  Yes” Is Selected

Q5-17 I disclosed some of my mental illness experience  at my high school so my peers could understand me better.

- ❍ Strongly Disagree (1)
- ❍ Disagree (2)
- ❍ Not sure (3)
- ❍ Agree (4)
- ❍ Strongly Agree (5)

Answer If “I disclosed my mental illness to classmates at my high school.  Yes” Is Selected

Q5-18 I disclosed some of my mental illness experience at my high school in order to share details about my life and deepen friendships.

- ❍ Strongly Disagree (1)
- ❍ Disagree (2)
- ❍ Not sure (3)
- ❍ Agree (4)
- ❍ Strongly Agree (5)

Q5-19 When I was in high school, I disclosed some of my mental illness experience to my boy/girlfriend.

- ❍ Yes (1)
- ❍ No (2)
- ❍ I didn't have a boyfriend or girlfriend in high school (3)

Answer If “When I was in high school, I spoke about my mental illness with my boy/girlfriend. Yes” Is Selected

Q5-20 I disclosed some of my mental illness experience with my high school boy/girlfriend in order to deepen our relationship.

- ❍ Strongly Disagree (1)
- ❍ Disagree (2)
- ❍ Not sure (3)
- ❍ Agree (4)
- ❍ Strongly Agree (5)

Q5-21 When I was in high school, I disclosed some of my mental illness experience to peers who also have mental illness in an advocacy or support-group (e.g, NAMI) outside of school.

- ❍ Yes (1)
- ❍ No (2)

Q5-22 When I was in high school, I disclosed some of my mental illness experience to peers in a mental health advocacy, awareness, or education club at my school.
- Yes (1)
- No (2)

Q5-23 When I was in high school, I disclosed some of my mental illness experience at a public event outside of school related to mental health advocacy, awareness, education, or fundraising.
- Yes (1)
- No (2)

Q5-23 When I was in high school, I disclosed some of my mental illness experience because I am comfortable with myself and it is part of me.
- Strongly Disagree (1)
- Disagree (2)
- Not sure (3)
- Agree (4)
- Strongly Agree (5)

Q5-24 When I was in high school, I disclosed some of my mental illness experience because it was a relief to not keep it a secret.
- Strongly Disagree (1)
- Disagree (2)
- Not sure (3)
- Agree (4)
- Strongly Agree (5)

Q5-25 When I was in high school, I disclosed some of my mental illness experience only when it was so obvious that I could no longer hide it (e.g., after a hospitalization and subsequent return to school).
- Strongly Disagree (1)
- Disagree (2)
- Not sure (3)
- Agree (4)
- Strongly Agree (5)

Q5-26 When I was in high school, I disclosed some of my mental illness experience because I wanted to change people's negative attitudes about mental illness.
- Strongly Disagree (1)
- Disagree (2)
- Not sure (3)
- Agree (4)
- Strongly Agree (5)

Q5-27 When I was in high school, I disclosed some of my mental illness experience in order to be a role model for other young people considering disclosing their own mental illnesses.

- ❍ Strongly Disagree (1)
- ❍ Disagree (2)
- ❍ Not sure (3)
- ❍ Agree (4)
- ❍ Strongly Agree (5)

Q5-28 When I was in high school, I disclosed some of my mental illness experience so that people could better support me if I needed help related to managing my illness.

- ❍ Strongly Disagree (1)
- ❍ Disagree (2)
- ❍ Not sure (3)
- ❍ Agree (4)
- ❍ Strongly Agree (5)

Q5-29 When I was in high school, I disclosed my mental illness online in order to broaden my network of peers who also have mental illness (e.g., in chat rooms, other online forums, and/or through Twitter or a blog).

- ❍ Strongly Disagree (1)
- ❍ Disagree (2)
- ❍ Not sure (3)
- ❍ Agree (4)
- ❍ Strongly Agree (5)

Answer If “I disclosed my mental illness to classmates at my high school. Yes” Is Selected

Q5-30 When I disclosed some of my mental illness experience at my high school, classmates at school listened respectfully.

- ❍ Strongly Disagree (1)
- ❍ Disagree (2)
- ❍ Not sure (3)
- ❍ Agree (4)
- ❍ Strongly Agree (5)

Answer If “I disclosed my mental illness to classmates at my high school.  Yes” Is Selected

Q5-31 When I disclosed some of my mental illness experience at my high school, classmates at school understood me.

- Strongly Disagree (1)
- Disagree (2)
- Not sure (3)
- Agree (4)
- Strongly Agree (5)

Answer If “I disclosed my mental illness to classmates at my high school.  Yes” Is Selected

Q5-32 When I disclosed some of my mental illness experience at my high school, classmates at school accepted me.

- Strongly Disagree (1)
- Disagree (2)
- Not sure (3)
- Agree (4)
- Strongly Agree (5)

Answer If “I disclosed my mental illness to classmates at my high school.  Yes” Is Selected

Q5-33 When I disclosed some of my mental illness experience at my high school, other students at school seemed uncomfortable.

- Strongly Disagree (1)
- Disagree (2)
- Not sure (3)
- Agree (4)
- Strongly Agree (5)

Answer If “I disclosed my mental illness to classmates at my high school.  Yes” Is Selected

Q5-34 When I disclosed some of my mental illness experience at my high school, other students treated me worse afterwards.

- Strongly Disagree (1)
- Disagree (2)
- Not sure (3)
- Agree (4)
- Strongly Agree (5)

Answer If “I disclosed my mental illness to classmates at my high school.  Yes” Is Selected

Q5-35 When I disclosed some of my mental illness experience at my high school, other students treated me better afterwards.

- Strongly Disagree (1)
- Disagree (2)
- Not sure (3)
- Agree (4)
- Strongly Agree (5)

Answer If “I disclosed my mental illness to classmates at my high school.  Yes” Is Selected

Q5-36 When I disclosed some of my mental illness experience at my high school, other students treated me the same afterwards.

- Strongly Disagree (1)
- Disagree (2)
- Not sure (3)
- Agree (4)
- Strongly Agree (5)

Answer If “I disclosed my mental illness to classmates at my high school.  Yes” Is Selected

Q5-37 When I disclosed some of my mental illness experience at my high school, I lost friends.

- Strongly Disagree (1)
- Disagree (2)
- Not sure (3)
- Agree (4)
- Strongly Agree (5)

Answer If “I disclosed my mental illness to classmates at my high school.  Yes” Is Selected

Q5-38 When I disclosed some of my mental illness experience at my high school, I gained friends.

- Strongly Disagree (1)
- Disagree (2)
- Not sure (3)
- Agree (4)
- Strongly Agree (5)

Answer If “I disclosed my mental illness to classmates at my high school.  Yes” Is Selected

Q5-39 When I disclosed some of my mental illness experience at my high school, it didn't affect my friendships.

- ❍ Strongly Disagree (1)
- ❍ Disagree (2)
- ❍ Not sure (3)
- ❍ Agree (4)
- ❍ Strongly Agree (5)

Q5-40 I didn't have any friends in high school.

- ❍ Strongly Disagree (1)
- ❍ Disagree (2)
- ❍ Not sure (3)
- ❍ Agree (4)
- ❍ Strongly Agree (5)

Q5-41 As a high school student, I mentioned my mental illness on social media (blogs, chat rooms, forums, Twitter, etc.) to people that I already knew in person.

- ❍ Yes (1)
- ❍ No (2)

Q5-42 As a high school student, I mentioned my  mental illness on social media (blogs, chat rooms, forums, Twitter,  etc.) to people that I did not know in person.

- ❍ Yes (1)
- ❍ No (2)

Q5-43 As a high school student, I wrote about my mental illness in certain school assignments.

- ❍ Yes (1)
- ❍ No (2)

Q5-44 As a high school student, I mentioned my mental illness in my college application essay.

- ❍ Yes (1)
- ❍ No (2)

Q5-45 Aside from the reasons mentioned above, are there any other reasons that you disclosed some of your mental illness experience with friends, classmates, boy/girlfriends, teachers, or other adults in your life when you were in high school? If so, please describe them here:

Q5-46 People to whom I disclosed in high school (please select all that apply):

- ❑ No one (1)
- ❑ My best friend (2)
- ❑ My boyfriend/girlfriend (3)
- ❑ A small group of friends at my school (4)
- ❑ A small group of friends not from my school (5)
- ❑ A large group of friends at my school (e.g. "everybody I hang with" or "people in my clique") (6)
- ❑ A large group of friends not from my school (7)
- ❑ Certain classmates at my school (8)
- ❑ All of my classmates at my school (9)
- ❑ One trusted teacher at my school (10)
- ❑ A small group of teachers at my school (11)
- ❑ All of the teachers my school (12)
- ❑ A guidance counselor, social worker, or psychologist at my school (13)
- ❑ A coach or other trusted adult at school (who is not a teacher or counselor) (14)
- ❑ Members of my sports team/band/club/or other school-based group (15)
- ❑ A trusted adult or mentor who works with me outside of school (e.g., camp counselor, clergy person, tutor) (16)
- ❑ Other (17)

Q5-47 If "Other" is selected above, please write in additional people to whom you disclosed in high school here:

Answer If “Please select the statement, below, that is most accurate for you: In high school, I did not disclose to anyone” Is Selected

Q5-48 What are the reasons that you decided not to tell anyone at your high school about your mental illness? (Please select all that apply.)

- ❑ It wasn't relevant because my mental health problems started after high school (1)
- ❑ It wasn't anyone's business (2)
- ❑ I was afraid that people would think less of me (3)
- ❑ I was afraid that I would lose friends (4)
- ❑ I didn't want any special treatment (5)
- ❑ I didn't want to stand out as different (6)
- ❑ If I had told one person, they might not have kept it a secret and other people could have found out (7)
- ❑ It wasn't a big deal. I was a high school student just like everyone else. (8)
- ❑ Other (9)

Answer If “What are the reasons that you decided not to tell anyone at your high school about your mental illness? (Please select all that apply.) Other” Is Selected

Q5-49 If you selected "other," above, please list your additional reasons for not telling anyone at hour high school about your mental illness here:

**VI. The next section of the survey is about your experience preparing for college.**

For the questions below, please mark whether you *Strongly Disagree, Disagree,* are *Not Sure, Agree*, or *Strongly Agree*.

Q6-01 I always knew that I would go to college.
- ❍ Strongly Disagree (1)
- ❍ Disagree (2)
- ❍ Not Sure (3)
- ❍ Agree (4)
- ❍ Strongly Agree (5)

Q6-02 I spent a lot of time thinking about college when I was in high school.
- ❍ Strongly Disagree (1)
- ❍ Disagree (2)
- ❍ Not Sure (3)
- ❍ Agree (4)
- ❍ Strongly Agree (5)

Q6-03 I put a lot of effort into planning for college when I was in high school.
- ❍ Strongly Disagree (1)
- ❍ Disagree (2)
- ❍ Not Sure (3)
- ❍ Agree (4)
- ❍ Strongly Agree (5)

Q6-04 I received assistance and support from high school teachers and staff regarding applying to college.
- ❍ Strongly Disagree (1)
- ❍ Disagree (2)
- ❍ Not Sure (3)
- ❍ Agree (4)
- ❍ Strongly Agree (5)

Q6-05 I received assistance and support from my parent(s)/caregiver(s) regarding applying to college.
- ❍ Strongly Disagree (1)
- ❍ Disagree (2)
- ❍ Not Sure (3)
- ❍ Agree (4)
- ❍ Strongly Agree (5)

Q6-06 When thinking about whether to attend college, I considered my mental illness and how it might influence my college experience.

- ❍ Strongly Disagree (1)
- ❍ Disagree (2)
- ❍ Not Sure (3)
- ❍ Agree (4)
- ❍ Strongly Agree (5)

Q6-07 When thinking about to which colleges I should apply, I considered my mental illness.

- ❍ Strongly Disagree (1)
- ❍ Disagree (2)
- ❍ Not Sure (3)
- ❍ Agree (4)
- ❍ Strongly Agree (5)

Q6-08 When researching colleges, I investigated what types of services and supports certain schools have for students with mental illnesses.

- ❍ Strongly Disagree (1)
- ❍ Disagree (2)
- ❍ Not Sure (3)
- ❍ Agree (4)
- ❍ Strongly Agree (5)

Q6-09 I contacted certain colleges to inquire about their services and supports for students with mental health challenges.

- ❍ Strongly Disagree (1)
- ❍ Disagree (2)
- ❍ Not Sure (3)
- ❍ Agree (4)
- ❍ Strongly Agree (5)

Q6-10 I applied to certain colleges based on the services and supports they offer to students with mental health challenges.

- ❍ Strongly Disagree (1)
- ❍ Disagree (2)
- ❍ Not Sure (3)
- ❍ Agree (4)
- ❍ Strongly Agree (5)

Q6-11 When thinking about attending college, I considered whether I might need to access academic accommodations while in college because of my mental illness.

- ❍ Strongly Disagree (1)
- ❍ Disagree (2)
- ❍ Not Sure (3)
- ❍ Agree (4)
- ❍ Strongly Agree (5)

Q6-12 I learned about accessing college academic accommodations related to my mental illness when I was in high school.

- ❍ Strongly Disagree (1)
- ❍ Disagree (2)
- ❍ Not Sure (3)
- ❍ Agree (4)
- ❍ Strongly Agree (5)

Q6-13 A high school teacher or school guidance counselor discussed accessing college academic accommodations with me before going to college.

- ❍ Strongly Disagree (1)
- ❍ Disagree (2)
- ❍ Not Sure (3)
- ❍ Agree (4)
- ❍ Strongly Agree (5)

Q6-14 My parent(s)/caregiver(s) discussed accessing college academic accommodations with me before going to college.

- ❍ Strongly Disagree (1)
- ❍ Disagree (2)
- ❍ Not Sure (3)
- ❍ Agree (4)
- ❍ Strongly Agree (5)

Q6-15 My psychiatrist, psychologist, or mental health counselor/social worker discussed accessing college academic accommodations with me before going to college.

- ❍ Strongly Disagree (1)
- ❍ Disagree (2)
- ❍ Not Sure (3)
- ❍ Agree (4)
- ❍ Strongly Agree (5)

Q6-16 When applying to college, I was aware of the Americans with Disabilities Act (ADA) and what it means for post-secondary (after high school) education for students with disabilities.

- ❍ Strongly Disagree (1)
- ❍ Disagree (2)
- ❍ Not Sure (3)
- ❍ Agree (4)
- ❍ Strongly Agree (5)

Q6-17 When applying to college, I was aware of Section 504 of the Rehabilitation Act, and what it means for post-secondary education (after high school) for students with disabilities.

- ❍ Strongly Disagree (1)
- ❍ Disagree (2)
- ❍ Not Sure (3)
- ❍ Agree (4)
- ❍ Strongly Agree (5)

Q6-18 When applying to college, I was aware of the Individuals with Disabilities Education Act (IDEA) and what it means for children and youth with disabilities and their education.

- ❍ Strongly Disagree (1)
- ❍ Disagree (2)
- ❍ Not Sure (3)
- ❍ Agree (4)
- ❍ Strongly Agree (5)

Q6-19 I knew how a student with a psychiatric disability could access academic accommodations at the colleges to which I applied.

- ❍ Strongly Disagree (1)
- ❍ Disagree (2)
- ❍ Not Sure (3)
- ❍ Agree (4)
- ❍ Strongly Agree (5)

Q6-20 I was aware of the services and supports currently in place for students with disabilities at the colleges to which I applied.

- ❍ Strongly Disagree (1)
- ❍ Disagree (2)
- ❍ Not Sure (3)
- ❍ Agree (4)
- ❍ Strongly Agree (5)

Q6-21 I considered a college's geographic location when thinking about which school to attend.

- ❍ Strongly Disagree (1)
- ❍ Disagree (2)
- ❍ Not Sure (3)
- ❍ Agree (4)
- ❍ Strongly Agree (5)

Answer If "Agree" Is Selected Or "Strongly Agree" Is Selected

Q6-22 I considered schools' geographic locations when applying to college because: (Please check the boxes next to statements that are most accurate for you)

- ❑ I wanted to be close enough to home so that I could drive there if I needed a break from school (1)
- ❑ I planned to live at home with my parents/caregivers and commute to school (2)
- ❑ I wanted to be close to a hospital or medical center in case I needed emergency psychiatric treatment (3)
- ❑ I wanted to be close enough to my current psychiatrist/psychologist/counselor that I could continue to see him or her (4)
- ❑ I wanted to move away from home and start over in a new town or city, where no one knew about my mental illness (5)
- ❑ I wanted to be independent from my parents/caregivers and live on my own. (6)
- ❑ Other (7)

Answer If "Other" Is Selected

Q6-23 If you selected "Other," above, please describe your reason(s) for considering colleges' geographic locations here:

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**VII. This section of the survey is about your higher education experiences, and the type of college or university you attend.**

Q7-01 I currently:

- ❍ attend a 2-year college part-time (1)
- ❍ attend a 2-year college full-time (2)
- ❍ attend a 4-year college or university part-time (3)
- ❍ attend a 4-year college or university full-time (4)

Answer If “I currently attend a 2-year college part-time Is Selected Or I currently attend a 2-year college full-time” Is Selected

Q7-02 I am currently in (or about to begin) the following year of my Associates degree program

- 1st year of a 2-year progarm (1)
- 2nd year of a 2-year program (2)
- 3rd year of a 2-year program (3)
- 4th year of a 2-year program (4)
- 5th (or more) year of a 2-year program (5)

Answer If “I currently: attend a 4-year college or university part-time” Is Selected Or “I currently: attend a 4-year college or university full-time” Is Selected

Q7-03 I am currently in (or about to begin) the following year of my Bachelors degree program:

- 1st year of a 4-year degree program (1)
- 2nd year of a 4-year degree program (2)
- 3rd year of a 4-year degree program (3)
- 4th year of a 4-year degree program (4)
- 5th year of a 4-year degree program (5)
- 6th year of a 4-year degree program (6)
- 7th year (or more) of a 4-year degree program (7)

Q7-04 My college or university is

- public (1)
- private (2)

Q7-05 I currently take my college courses

- all in-person on campus (1)
- all online (2)
- some in-person on campus and some online (3)

Q7-06 If you feel comfortable sharing this information, please type in the name of your college or university here:

Q7-07 Approximate number of undergraduate students currently attending my school (please type in your response, below):

- less than 1000 undergraduates (1)
- 1001 - 2500 undergraduates (2)
- 2501 - 5000 undergraduates (3)
- 5001 - 10,000 undergraduates (4)
- 10,001 - 20,000 undergraduates (5)
- more than 20,000 undergraduates (6)

Q7-08 The higher education institution I currently attend could be described as:
- ❍ a residential Liberal Arts college (1)
- ❍ a private residential research university (2)
- ❍ a public residential research university (3)
- ❍ a public "commuter" school (as opposed to a residential college) (4)
- ❍ a community college (5)

Q7-09 The following best describes where I lived during the past academic year:
- ❍ Single dorm room or other campus housing alone (1)
- ❍ Dorm room or suite, or other campus housing with roommates (2)
- ❍ Off-campus alone (3)
- ❍ Off-campus with roommates (4)
- ❍ At home with my family; I commute to school (5)

Q7-10 Your approximate college grade point average (GPA) for your most recent academic year, on a 4 point scale:
- ❍ 1.0 (1)
- ❍ 1.5 (2)
- ❍ 2.0 (3)
- ❍ 2.5 (4)
- ❍ 3 (5)
- ❍ 3.5 (6)
- ❍ 4 (7)
- ❍ 4.5 (8)
- ❍ 5 (9)

Q7-11 How old were you when you first entered college? (Please write in the number, below):

Q7-12 Did you enter college in the Fall term, immediately completing high school?
- ❍ Yes (1)
- ❍ No (2)

Answer If “Did you enter college in the Fall term, immediately completing high school? No” Is Selected

Q7-13 Approximately how many months or years passed between you completing high school and entering college for the first time?

- 6 months (1)
- 1 year (2)
- 1 year and 6 months (3)
- 2 years (4)
- 2 years and 6 months (5)
- 3 years (6)
- 3 years and 6 months (7)
- 4 years (8)
- 4 years and 6 months (9)
- 5 years (10)
- 5 years and 6 months (11)
- 6 years or more (12)

Q7-14 The degree you are currently working toward

- Associates degree (AA or AS) (1)
- Bachelors degree (BA or BS) (2)
- Other (3)

Answer If “The degree you are currently working toward Other” Is Selected

Q7-15 If you answered "Other" above, please write in what degree you are currently working toward:

Q7-16 What is the highest degree that you plan to attain in the future?

- Bachelors degree (B.A., B.S.) (1)
- Masters degree (e.g., M.A., M.S., M.S.Ed., M.S.W.) (2)
- Professional or Terminal Degree (e.g., J.D., M. D., M.F.A.) (3)
- Doctoral degree (e.g., Ph.D., Ed.D., Psy.D) (4)

Answer If “The degree you are currently working toward Bachelors degree (BA or BS)” Is Selected

Q7-17 The year you anticipate completing your Bachelors degree (please write in the year, below):

Q7-18 Have you already completed your Bachelors degree?

- Yes (1)
- No (2)

Answer If “Have you already completed your Bachelors degree? Yes” Is Selected

Q7-19 If you have already completed your Bachelors degree, please write in your graduation year, below:

Answer If “The degree you are currently working toward Bachelors degree (BA or BS)” Is Selected

Q7-20 Have you already completed an Associates degree?

- ❍ Yes (1)
- ❍ No (2)

Answer If “Have you already completed an Associates degree? Yes” Is Selected

Q7-21 Please write in the year you earned an AA below:

Q7-22 Have you declared a college Major?

- ❍ Yes (1)
- ❍ No (2)

Answer If “Have you declared a college Major? Yes” Is Selected

Q7-23 What is your Major? (Please write in your response, below.)

Q7-24 In the past year, have you participated in extra--curricular activities in college?

- ❍ Yes (1)
- ❍ No (2)

Answer If “Do you participate in extra-curricular activities in college? Yes” Is Selected

Q7-25 Please check all of the college extra-curriculars you have participated in over the past year:

- ❑ Band, Orchestra, Music, A Capella (1)
- ❑ Drama club, Theater, School plays (2)
- ❑ Sports (3)
- ❑ Student Government (4)
- ❑ Yearbook (5)
- ❑ Other (6)

Answer If “Please check all of the college extra-curriculars you have participated in over the past year: Sports” Is Selected

Q7-26 Please list the sport(s) that you have played in college (varsity or intramural) over the past year here. (Type in your responses, separating different sports with a comma.)

Answer If “Please check all of the college extra-curriculars you have participated in over the past year: Other” Is Selected

Q7-27 Please describe the other college extra-curricular(s) that you have participated in over the past year here. (Type in your responses, separating different activities with a comma.)

Q7-28 In the past year, approximately how many hours of extra-curricular college activities have you participated in each week?

- ❍ Less than 1 hour/week (1)
- ❍ 1 - 2 hours/week (2)
- ❍ 2 or more hours/week (3)

Q7-29 Does your college have a mental health awareness, education, or advocacy club?

- ❍ Yes (1)
- ❍ No (2)
- ❍ I don't know (3)

Answer If “Does your college have a mental health awareness, education, or advocacy club? Yes” Is Selected

Q7-30 Have you ever been a member of this club?

- ❍ Yes (1)
- ❍ No (2)

Answer If “Does your college have a mental health awareness, education, or advocacy club? Yes” Is Selected

Q7-31 Are you currently a member of this club?

- ❍ Yes (1)
- ❍ No (2)

Answer If “Does your college have a mental health awareness, education, or advocacy club? Yes” Is Selected

Q7-32 What is the name of your college mental health awareness, education, or advocacy club?

- ❍ Active Minds (1)
- ❍ NAMI on Campus (2)
- ❍ Let's Erase the Stigma (LETS) (3)
- ❍ I don't know (4)
- ❍ Other (5)

Answer If “What is the name of your college mental health awareness, education, or advocacy club? Other” Is Selected

Q7-33 If “Other,” above, please type in the name of your college’s mental health awareness, education, or advocacy club here:

Q7-34 In the past year, have you worked for pay during the academic year while in college?

- ❍ Yes (1)
- ❍ No (2)

Answer If “In the past year, did you work for pay while in college? Yes” Is Selected

Q7-35 Over the past year, about how many hours per week have you worked for pay while college? (Please write in your response, below.)

Answer If “In the past year, did you work for pay while in college? Yes” Is Selected

Q7-36 Over the past year, what type of paid job or jobs have you had? (Please write in your response, below.)

Q7-37 In the past year, have you done any volunteer work during the academic year while in college?

- ❍ Yes (1)
- ❍ No (2)

Answer If “In the past year, have you done any volunteer work while in college? Yes” Is Selected

Q7-38 In the past academic year, about how many hours per week have you volunteered while in college? (Please write in your response, below.)

Answer If “In the past year, have you done any volunteer work while in college? Yes” Is Selected

Q7-39 What type of volunteer work have you done? (Please write in your response, below.)

Q7-40 In the past year, have you participated in a “Supported Education” program (a special program for college students with mental illnesses that helps students stay in school and meet their goals)?

- ❍ Yes (1)
- ❍ No (2)

Please complete the following question by marking whether you Strongly Disagree, Disagree, are Not Sure, Agree, or Strongly Agree.

Answer If “In the past year, have you participated in a “Supported Education” program (a special program for college students with mental illnesses that helps students stay in school and meet their goals)? Yes” Is Selected

Q7-41 The Supported Education program that I have participated in has contributed to my success in college.

- ❍ Strongly Disagree (1)
- ❍ Disagree (2)
- ❍ Not Sure (3)
- ❍ Agree (4)
- ❍ Strongly Agree (5)

**Please select the response that best completes the following statements.**

Q7-42 The college I currently attend is my _____

- ❍ first choice school (1)
- ❍ second choice school (2)
- ❍ third choice school (3)
- ❍ 4th choice school (4)
- ❍ 5th or lower choice school (5)
- ❍ I didn't have a preference regarding what college to attend (6)

Q7-43 The college I currently attend has an office serving students with disabilities.

- ❍ Yes (1)
- ❍ No (2)
- ❍ I don't know (3)

Answer If “The college I currently attend has an office serving students with disabilities. Yes” Is Selected

Q7-44 Because of my mental illness, I have accessed services (e.g. academic accommodations) on my campus through the Student Disability Services office.

- ❍ Yes (1)
- ❍ No (2)

Answer If “Because of my mental illness, I have accessed services (e.g. academic accommodations) on my campus through the Student Disability Services office. Yes” Is Selected

Q7-45 Please describe why you chose to access accommodations in the space below:

Answer If “Because of my mental illness, I have accessed services (e.g. academic accommodations) on my campus through the Student Disability Services office. Yes” Is Selected

Q7-46 Please describe what services you accessed:

**Please complete the following questions by marking whether you *Strongly Disagree, Disagree*, are *Not Sure, Agree*, or *Strongly Agree*.**

Answer If "Because of my mental illness, I have accessed services (e.g. academic accommodations) on my campus through the Student Disability Services office Yes" Is Selected

Q7-47 The accommodations I have received through Student Disability Services have contributed to my success in college.

- ❍ Strongly disagree (1)
- ❍ Disagree (2)
- ❍ Not Sure (3)
- ❍ Agree (4)
- ❍ Strongly Agree (5)

Answer If "Because of my mental illness, I have accessed services (e.g. academic accommodations) on my campu... Yes" Is Selected

Q7-48 On the whole, I believe that my college offers a friendly learning environment for students with disabilities.

- ❍ Strongly disagree (1)
- ❍ Disagree (2)
- ❍ Not Sure (3)
- ❍ Agree (4)
- ❍ Strongly Agree (5)

Answer If "Because of my mental illness, I have accessed services (e.g. academic accommodations) on my campu... Yes" Is Selected

Q7-49 Overall, my experience with the Student Disability Services office on my campus has been positive.

- ❍ Strongly disagree (1)
- ❍ Disagree (2)
- ❍ Not Sure (3)
- ❍ Agree (4)
- ❍ Strongly Agree (5)

Answer If "Because of my mental illness, I have accessed services (e.g. academic accommodations) on my campu... Yes" Is Selected

Q7-50 My professors have respected my right to confidentiality by not revealing my identity as a student with a disability to other students in the class.

- ❍ Strongly disagree (1)
- ❍ Disagree (2)
- ❍ Not Sure (3)
- ❍ Agree (4)
- ❍ Strongly Agree (5)

Answer “If Because of my mental illness, I have accessed services (e.g. academic accommodations) on my campu... Yes” Is Selected

Q7-51 Generally, my professors have been responsive in providing the accommodations recommended by the Student Disability Services office.

- ❍ Strongly disagree (1)
- ❍ Disagree (2)
- ❍ Not Sure (3)
- ❍ Agree (4)
- ❍ Strongly Agree (5)

Answer If “Because of my mental illness, I have accessed services (e.g. academic accommodations) on my campu... Yes” Is Selected

Q7-52 No member of the faculty, administration, or staff has discriminated against me due to my disability.

- ❍ Strongly disagree (1)
- ❍ Disagree (2)
- ❍ Not Sure (3)
- ❍ Agree (4)
- ❍ Strongly Agree (5)

Answer If “Because of my mental illness, I have accessed services (e.g. academic accommodations) on my campu... No” Is Selected

Q7-53 What is the reason (or reasons) that you have not utilized academic accommodations offered through the Student Disability Services office your college or university? (Please select all that apply.)

- ❑ I don't qualify for those services because I don't have a physical disability (1)
- ❑ I don't identify myself as someone who as a "disability" (2)
- ❑ I am embarrassed about telling staff about my mental illness (3)
- ❑ It will take too much paperwork or time to set it up (4)
- ❑ I don’t want my classmates to find out (5)
- ❑ I don’t want my professors to think that I’m getting special treatment (6)
- ❑ I don’t need accommodations (7)
- ❑ They don't offer the kind of services that would help me (8)
- ❑ Other (9)

Answer If “What is the reason (or reasons) that you have not utilized academic accommodations offered through the Student Disability Services office your college or university? (Please select all that apply.) They don't offer the kind of services that would help me” Is Selected

Q7-54 What kind of services or accommodations would be most useful to you?

Answer If “What is the reason (or reasons) that you have not utilized academic accommodations offered through the Student Disability Services office your college or university? (Please select all that apply.) Other” Is Selected

Q7-55 If "Other," above, please describe your additional reasons for not accessing academic accommodations here:

Q7-56 The college I currently attend has a Counseling and Psychological services office.

- ❍ Yes (1)
- ❍ No (2)
- ❍ I don't know (3)

Q7-57 I have accessed resources or supports at my campus Counseling and Psychological Services office.

- ❍ Yes (1)
- ❍ No (2)

Answer If “I have accessed resources or supports at my campus Counseling and Psychological Services office. Yes” Is Selected

Q7-58 The resources and supports I have received at my campus Counseling and Psychological Services office have contributed to my success in college.

- ❍ Strongly Disagree (1)
- ❍ Disagree (2)
- ❍ Not Sure (3)
- ❍ Agree (4)
- ❍ Strongly Agree (5)

Q7-59 In college, I have at least one good friend that I trust and can talk to if I need support.

- ❍ Strongly Disagree (1)
- ❍ Disagree (2)
- ❍ Not Sure (3)
- ❍ Agree (4)
- ❍ Strongly Agree (5)

Answer If “In college, I have at least one good friend that I trust and can talk to if I need support. “Agree” or “Strongly Agree” Is Selected

Q7-60 This trusted friend also has a mental illness.

- ❍ Yes (1)
- ❍ No (2)
- ❍ I don't know (3)

Q7-61 As a college student, I am satisfied with my social life.
- ❍ Strongly Disagree (1)
- ❍ Disagree (2)
- ❍ Not Sure (3)
- ❍ Agree (4)
- ❍ Strongly Agree (5)

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**VIII. This section of the survey is about your general social and academic experiences in college.**

Please complete the following questions by marking whether you *Strongly Disagree, Disagree*, are *Not Sure*, *Agree,* or *Strongly Agree*.

Q8-01 Since coming to this college or university I have developed close personal relationships with other students.
- ❍ Strongly Disagree (1)
- ❍ Disagree (2)
- ❍ Not Sure (3)
- ❍ Agree (4)
- ❍ Strongly Agree (5)

Q8-02 The student friendships I have developed at this college or university have been personally satisfying.
- ❍ Strongly Disagree (1)
- ❍ Disagree (2)
- ❍ Not Sure (3)
- ❍ Agree (4)
- ❍ Strongly Agree (5)

Q8-03 My interpersonal relationships with other students have had a positive influence on my personal growth, attitudes, and values.
- ❍ Strongly Disagree (1)
- ❍ Disagree (2)
- ❍ Not Sure (3)
- ❍ Agree (4)
- ❍ Strongly Agree (5)

Q8-04 My interpersonal relationships with other students have had a positive influence on my intellectual growth and interest in ideas.
- ❍ Strongly Disagree (1)
- ❍ Disagree (2)
- ❍ Not Sure (3)
- ❍ Agree (4)
- ❍ Strongly Agree (5)

Q8-05 It has been difficult for me to meet and make friends with other students.
- ❍ Strongly Disagree (1)
- ❍ Disagree (2)
- ❍ Not Sure (3)
- ❍ Agree (4)
- ❍ Strongly Agree (5)

Q8-06 Few of the students I know would be willing to listen to me and help me if I had a personal problem.
- ❍ Strongly Disagree (1)
- ❍ Disagree (2)
- ❍ Not Sure (3)
- ❍ Agree (4)
- ❍ Strongly Agree (5)

Q8-07 Most students at this college or university have values and attitudes different from my own.
- ❍ Strongly Disagree (1)
- ❍ Disagree (2)
- ❍ Not Sure (3)
- ❍ Agree (4)
- ❍ Strongly Agree (5)

Q8-08 My non-classroom interactions with faculty have had a positive influence on my personal growth, values, and attitudes.
- ❍ Strongly Disagree (1)
- ❍ Disagree (2)
- ❍ Not Sure (3)
- ❍ Agree (4)
- ❍ Strongly Agree (5)

Q8-09 My non-classroom interactions with faculty have had a positive influence on my intellectual growth and interest in ideas.
- ❍ Strongly Disagree (1)
- ❍ Disagree (2)
- ❍ Not Sure (3)
- ❍ Agree (4)
- ❍ Strongly Agree (5)

Q8-10 My non-classroom interactions with faculty have had a positive influence on my career goals and aspirations.
- ❍ Strongly Disagree (1)
- ❍ Disagree (2)
- ❍ Not Sure (3)
- ❍ Agree (4)
- ❍ Strongly Agree (5)

Q8-11 Since coming to this college or university I have developed a close, personal relationship with at least one faculty member.
- ❍ Strongly Disagree (1)
- ❍ Disagree (2)
- ❍ Not Sure (3)
- ❍ Agree (4)
- ❍ Strongly Agree (5)

Q8-12 I am satisfied with the opportunities to meet and interact informally with faculty members.
- ❍ Strongly Disagree (1)
- ❍ Disagree (2)
- ❍ Not Sure (3)
- ❍ Agree (4)
- ❍ Strongly Agree (5)

Q8-13 Few of the faculty members I have had contact with are generally interested in students.
- ❍ Strongly Disagree (1)
- ❍ Disagree (2)
- ❍ Not Sure (3)
- ❍ Agree (4)
- ❍ Strongly Agree (5)

Q8-14 Few of the faculty members I have had contact with are generally outstanding or superior teachers.
- ❍ Strongly Disagree (1)
- ❍ Disagree (2)
- ❍ Not Sure (3)
- ❍ Agree (4)
- ❍ Strongly Agree (5)

Q8-15 Few of the faculty members I have had contact with are willing to spend time outside of class to discuss issues of interest and importance to students.
- ❍ Strongly Disagree (1)
- ❍ Disagree (2)
- ❍ Not Sure (3)
- ❍ Agree (4)
- ❍ Strongly Agree (5)

Q8-16 Most of the faculty I have had contact with are interested in helping students grow in more than just academic areas.
- ❍ Strongly Disagree (1)
- ❍ Disagree (2)
- ❍ Not Sure (3)
- ❍ Agree (4)
- ❍ Strongly Agree (5)

Q8-17 Most faculty members I have had contact with are genuinely interested in teaching.
- ❍ Strongly Disagree (1)
- ❍ Disagree (2)
- ❍ Not Sure (3)
- ❍ Agree (4)
- ❍ Strongly Agree (5)

Q8-18 I am satisfied with the extent of my intellectual development since enrolling in this college or university.
- ❍ Strongly Disagree (1)
- ❍ Disagree (2)
- ❍ Not Sure (3)
- ❍ Agree (4)
- ❍ Strongly Agree (5)

Q8-19 My academic experience has had a positive influence on my intellectual growth and interest in ideas.
- ❍ Strongly Disagree (1)
- ❍ Disagree (2)
- ❍ Not Sure (3)
- ❍ Agree (4)
- ❍ Strongly Agree (5)

Q8-20 I am satisfied with my academic experience at this college or university.
- ❍ Strongly Disagree (1)
- ❍ Disagree (2)
- ❍ Not Sure (3)
- ❍ Agree (4)
- ❍ Strongly Agree (5)

Q8-21 Few of my courses this year have been intellectually stimulating.
- ❍ Strongly Disagree (1)
- ❍ Disagree (2)
- ❍ Not Sure (3)
- ❍ Agree (4)
- ❍ Strongly Agree (5)

Q8-22 My interest in ideas and intellectual matters has increased since coming to this college or university.
- ❍ Strongly Disagree (1)
- ❍ Disagree (2)
- ❍ Not Sure (3)
- ❍ Agree (4)
- ❍ Strongly Agree (5)

Q8-23 I am more likely to attend a cultural event (for example, a concert, lecture, or art show) now than I was before coming to this college or university.
- ❍ Strongly Disagree (1)
- ❍ Disagree (2)
- ❍ Not Sure (3)
- ❍ Agree (4)
- ❍ Strongly Agree (5)

Q8-24 I have performed academically as well as I anticipated I would.
- ❍ Strongly Disagree (1)
- ❍ Disagree (2)
- ❍ Not Sure (3)
- ❍ Agree (4)
- ❍ Strongly Agree (5)

Q8-25 It is important for me to graduate from college.
- ❍ Strongly Disagree (1)
- ❍ Disagree (2)
- ❍ Not Sure (3)
- ❍ Agree (4)
- ❍ Strongly Agree (5)

Q8-26 I am confident that I made the right decision in choosing to attend my current college or university.
- ❍ Strongly Disagree (1)
- ❍ Disagree (2)
- ❍ Not Sure (3)
- ❍ Agree (4)
- ❍ Strongly Agree (5)

Q8-27 It is likely that I will register at the same college or university I currently attend (unless I graduate) next Fall.
- ❍ Strongly Disagree (1)
- ❍ Disagree (2)
- ❍ Not Sure (3)
- ❍ Agree (4)
- ❍ Strongly Agree (5)

Q8-28 It is not important to me to graduate from the college or university I currently attend.
- ❍ Strongly Disagree (1)
- ❍ Disagree (2)
- ❍ Not Sure (3)
- ❍ Agree (4)
- ❍ Strongly Agree (5)

Q8-29 I have no idea at all what I want to major in.
- ❍ Strongly Disagree (1)
- ❍ Disagree (2)
- ❍ Not Sure (3)
- ❍ Agree (4)
- ❍ Strongly Agree (5)

Q8-30 Getting good grades is not important to me.
- ❍ Strongly Disagree (1)
- ❍ Disagree (2)
- ❍ Not Sure (3)
- ❍ Agree (4)
- ❍ Strongly Agree (5)

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**IX. This section of the survey is about whether and how you choose to tell people about your mental illness in COLLEGE.**

**We use the word "disclose" below, to mean if you told someone about your mental health challenges.**

Q9-01 Please select the statement, below, that is most accurate for you:
- ❍ In college, I have disclosed to most of the people in my daily life (1)
- ❍ In college, I have selectively disclosed to certain people in my daily life (2)
- ❍ In college, I have not disclosed to most of the people in my daily life (3)
- ❍ In college, I have not disclosed to anyone (4)

If “In college, I have not disclosed to anyone” Is Selected, Then Skip To “What are the reasons that you have decided not to disclose….”

Q9-02 I disclosed some of my mental illness experience to certain faculty or other staff at my college.
- ❍ Yes (1)
- ❍ No (2)

Please complete the following questions by marking whether you *Strongly Disagree*, *Disagree, Neither Agree nor Disagree*, *Agree*, or *Strongly Agree*.

Answer If “I disclosed my mental illness to certain faculty or other staff at my college. Yes” Is Selected

Q9-03 I disclosed some of my mental illness experience to faculty or other staff at my college in order to access formal academic services and accommodations.

- ❍ Strongly Disagree (1)
- ❍ Disagree (2)
- ❍ Neither Agree nor Disagree (3)
- ❍ Agree (4)
- ❍ Strongly Agree (5)

Answer If “I disclosed my mental illness to certain faculty or other staff at my college. Yes” Is Selected

Q9-04 I disclosed some of my mental illness experience to faculty and other staff at my college so they could understand me better.

- ❍ Strongly Disagree (1)
- ❍ Disagree (2)
- ❍ Neither Agree nor Disagree (3)
- ❍ Agree (4)
- ❍ Strongly Agree (5)

Answer If I” disclosed my mental illness to certain faculty or other staff at my college. Yes” Is Selected

Q9-05 I disclosed some of my mental illness experience to faculty and other staff at my college so they could help me with schoolwork if I needed support or had to miss class because of my illness.

- ❍ Strongly Disagree (1)
- ❍ Disagree (2)
- ❍ Neither Agree nor Disagree (3)
- ❍ Agree (4)
- ❍ Strongly Agree (5)

Answer If “I disclosed my mental illness to certain faculty or other staff at my college. Yes” Is Selected

Q9-06 In college, when I have disclosed some of my mental illness experience, faculty and school staff listened respectfully.

- ❍ Strongly Disagree (1)
- ❍ Disagree (2)
- ❍ Neither Agree nor Disagree (3)
- ❍ Agree (4)
- ❍ Strongly Agree (5)

Answer If “I disclosed my mental illness to certain faculty or other staff at my college. Yes” Is Selected

Q9-07 In college, when I have disclosed some of my mental illness experience, faculty and school staff understood me.

- ❍ Strongly Disagree (1)
- ❍ Disagree (2)
- ❍ Neither Agree nor Disagree (3)
- ❍ Agree (4)
- ❍ Strongly Agree (5)

Answer If “I disclosed my mental illness to certain faculty or other staff at my college. Yes” Is Selected

Q9-08 In college, when I have disclosed some of my mental illness experience, faculty and school staff accepted me.

- ❍ Strongly Disagree (1)
- ❍ Disagree (2)
- ❍ Neither Agree nor Disagree (3)
- ❍ Agree (4)
- ❍ Strongly Agree (5)

Answer If “I disclosed my mental illness to certain faculty or other staff at my college. Yes” Is Selected

Q9-09 In college, when I have disclosed some of my mental illness experience, faculty and school staff seemed uncomfortable.

- ❍ Strongly Disagree (1)
- ❍ Disagree (2)
- ❍ Neither Agree nor Disagree (3)
- ❍ Agree (4)
- ❍ Strongly Agree (5)

Answer If “I disclosed my mental illness to certain faculty or other staff at my college. Yes” Is Selected

Q9-10 In college, when I have disclosed some of my mental illness experience, faculty and school staff treated me worse afterwards.

- ❍ Strongly Disagree (1)
- ❍ Disagree (2)
- ❍ Neither Agree nor Disagree (3)
- ❍ Agree (4)
- ❍ Strongly Agree (5)

Answer If “I disclosed my mental illness to certain faculty or other staff at my college. Yes” Is Selected

Q9-11 In college, when I have disclosed some of my mental illness experience, faculty and school staff treated me better afterwards.

- ❍ Strongly Disagree (1)
- ❍ Disagree (2)
- ❍ Neither Agree nor Disagree (3)
- ❍ Agree (4)
- ❍ Strongly Agree (5)

Answer If “I disclosed my mental illness to certain faculty or other staff at my college. Yes” Is Selected

Q9-12 In college, when I have disclosed some of my mental illness experience, faculty and school staff treated me the same afterwards.

- ❍ Strongly Disagree (1)
- ❍ Disagree (2)
- ❍ Neither Agree nor Disagree (3)
- ❍ Agree (4)
- ❍ Strongly Agree (5)

Q9-13 I have disclosed some of my mental illness experience to certain friends and classmates at my college.

- ❍ Yes (1)
- ❍ No (2)

Answer If “I have disclosed my mental illness to certain friends and classmates at my college. Yes” Is Selected

Q9-14 I disclosed some of my mental illness experience to certain friends and classmates at my college so they could understand me better.

- ❍ Strongly Disagree (1)
- ❍ Disagree (2)
- ❍ Neither Agree nor Disagree (3)
- ❍ Agree (4)
- ❍ Strongly Agree (5)

Answer If “I have disclosed my mental illness to certain friends and classmates at my college. Yes” Is Selected

Q9-15 I disclosed some of my mental illness experience to certain friends and classmates at my college so they could help me with schoolwork if I needed support or had to miss class because of my illness.

- ❍ Strongly Disagree (1)
- ❍ Disagree (2)
- ❍ Neither Agree nor Disagree (3)
- ❍ Agree (4)
- ❍ Strongly Agree (5)

Answer If “I have disclosed my mental illness to certain friends and classmates at my college. Yes” Is Selected

Q9-16 I disclosed some of my mental illness experience to certain close friends in order to share details about my life and deepen our friendship.

- ❍ Strongly Disagree (1)
- ❍ Disagree (2)
- ❍ Neither Agree nor Disagree (3)
- ❍ Agree (4)
- ❍ Strongly Agree (5)

Answer If “I have disclosed my mental illness to certain friends and classmates at my college. Yes” Is Selected

Q9-17 I disclosed some of my mental illness experience to my boy/girlfriend in order to share details about my life and deepen our relationship.

- ❍ Strongly Disagree (1)
- ❍ Disagree (2)
- ❍ Neither Agree nor Disagree (3)
- ❍ Agree (4)
- ❍ Strongly Agree (5)

Q9-18 In college I disclosed some of my mental illness experience in an advocacy or support-group outside of school, with peers who also have mental illness (e.g, in a group like NAMI)

- ❍ Yes (1)
- ❍ No (2)

Answer If “I have disclosed my mental illness to certain friends and classmates at my college. Yes” Is Selected

Q9-19 In college, I have disclosed some of my mental illness experience to peers in a mental health advocacy/awareness/education club on my college campus.

- ❍ Yes (1)
- ❍ No (2)

Q9-20 In college, I have written about my mental illness online (e.g., in chat rooms, other online forums, and/or through Twitter or a blog)
- Yes (1)
- No (2)

Answer If “In college, I have written about my mental illness online (e.g., in chat rooms, other online forums, and/or through Twitter or a blog) Yes” Is Selected

Q9-21 I have written about my mental illness online in order to broaden my network of peers who also have mental illness.
- Strongly Disagree (1)
- Disagree (2)
- Neither Agree nor Disagree (3)
- Agree (4)
- Strongly Agree (5)

Q9-22 In college, I have disclosed some of my mental illness experience to people in my daily life because I am comfortable with myself and it is part of me.
- Strongly Disagree (1)
- Disagree (2)
- Neither Agree nor Disagree (3)
- Agree (4)
- Strongly Agree (5)

Q9-23 In college, I have disclosed some of my mental illness experience because it is a relief to not keep it a secret.
- Strongly Disagree (1)
- Disagree (2)
- Neither Agree nor Disagree (3)
- Agree (4)
- Strongly Agree (5)

Q9-24 In college, I have disclosed some of my mental illness experience only when it was so obvious that I could no longer hide it (e.g., after a hospitalization and subsequent return to school).
- Strongly Disagree (1)
- Disagree (2)
- Neither Agree nor Disagree (3)
- Agree (4)
- Strongly Agree (5)

Q9-25 In college, I have disclosed some of my mental illness experience because I think sharing my story could change people's negative attitudes about mental illness.

- ❍ Strongly Disagree (1)
- ❍ Disagree (2)
- ❍ Neither Agree nor Disagree (3)
- ❍ Agree (4)
- ❍ Strongly Agree (5)

Q9-26 In college, I have disclosed some of my mental illness experience in order to be a role model for other young people considering disclosing their own mental illness experience.

- ❍ Strongly Disagree (1)
- ❍ Disagree (2)
- ❍ Neither Agree nor Disagree (3)
- ❍ Agree (4)
- ❍ Strongly Agree (5)

Q9-27 In college, I have disclosed some of my mental illness experience so that people in my daily life can better support me if I need help related to managing my illness.

- ❍ Strongly Disagree (1)
- ❍ Disagree (2)
- ❍ Neither Agree nor Disagree (3)
- ❍ Agree (4)
- ❍ Strongly Agree (5)

Answer If “I have disclosed my mental illness to certain friends and classmates at my college. Yes” Is Selected

Q9-28 In college, when I have disclosed some of my mental illness experience, classmates and peers listened respectfully.

- ❍ Strongly Disagree (1)
- ❍ Disagree (2)
- ❍ Neither Agree nor Disagree (3)
- ❍ Agree (4)
- ❍ Strongly Agree (5)

Answer If “I have disclosed my mental illness to certain friends and classmates at my college. Yes” Is Selected

Q9-29 In college, when I have disclosed some of my mental illness experience, classmates and peers understood me.

- Strongly Disagree (1)
- Disagree (2)
- Neither Agree nor Disagree (3)
- Agree (4)
- Strongly Agree (5)

Answer If “I have disclosed my mental illness to certain friends and classmates at my college. Yes” Is Selected

Q9-30 In college, when I have disclosed some of my mental illness experience, classmates and peers accepted me.

- Strongly Disagree (1)
- Disagree (2)
- Neither Agree nor Disagree (3)
- Agree (4)
- Strongly Agree (5)

Answer If “I have disclosed my mental illness to certain friends and classmates at my college. Yes” Is Selected

Q9-31 In college, when I have disclosed some of my mental illness experience, classmates and peers seemed uncomfortable.

- Strongly Disagree (1)
- Disagree (2)
- Neither Agree nor Disagree (3)
- Agree (4)
- Strongly Agree (5)

Answer If “I have disclosed my mental illness to certain friends and classmates at my college. Yes” Is Selected

Q9-31 In college, when I have disclosed some of my mental illness experience, classmates and peers treated me worse afterwards.

- Strongly Disagree (1)
- Disagree (2)
- Neither Agree nor Disagree (3)
- Agree (4)
- Strongly Agree (5)

Answer If “I have disclosed my mental illness to certain friends and classmates at my college. Yes” Is Selected

Q9-32 In college, when I have disclosed some of my mental illness experience, classmates and peers treated me better afterwards.

- Strongly Disagree (1)
- Disagree (2)
- Neither Agree nor Disagree (3)
- Agree (4)
- Strongly Agree (5)

Answer If “I have disclosed my mental illness to certain friends and classmates at my college. Yes” Is Selected

Q9-33 In college, when I have disclosed some of my mental illness experience, classmates and peers treated me the same afterwards.

- Strongly Disagree (1)
- Disagree (2)
- Neither Agree nor Disagree (3)
- Agree (4)
- Strongly Agree (5)

Answer If “I have disclosed my mental illness to certain friends and classmates at my college. Yes” Is Selected

Q9-34 In college, when I have disclosed some of my mental illness experience, I lost friends.

- Strongly Disagree (1)
- Disagree (2)
- Neither Agree nor Disagree (3)
- Agree (4)
- Strongly Agree (5)

Answer If “I have disclosed my mental illness to certain friends and classmates at my college. Yes” Is Selected

Q9-35 In college, when I have disclosed some of my mental illness experience, I gained friends.

- Strongly Disagree (1)
- Disagree (2)
- Neither Agree nor Disagree (3)
- Agree (4)
- Strongly Agree (5)

Answer If “I have disclosed my mental illness to certain friends and classmates at my college. Yes” Is Selected

Q9-36 In college, when I have disclosed some of my mental illness experience, it didn't affect my friendships.

- Strongly Disagree (1)
- Disagree (2)
- Neither Agree nor Disagree (3)
- Agree (4)
- Strongly Agree (5)

Q9-37 I don't have any friends in college.

- Strongly Disagree (1)
- Disagree (2)
- Neither Agree nor Disagree (3)
- Agree (4)
- Strongly Agree (5)

Answer If “In college, I have written about my mental illness online (e.g., in chat rooms, other online forums, and/or through Twitter or a blog) Yes” Is Selected

Q9-38 As a college student, I have mentioned my mental illness on social media (blogs, chat rooms, forums, Twitter, etc.) to people that I already know in person.

- Yes (1)
- No (2)

Answer If “In college, I have written about my mental illness online (e.g., in chat rooms, other online forums, and/or through Twitter or a blog) Yes” Is Selected

Q9-39 As a college student, I mentioned my mental illness on social media (blogs, chat rooms, forums, Twitter, etc.) to people that I have not met in person.

- Yes (1)
- No (2)

Q9-40 As a college student, I have written about my mental illness in certain school assignments.

- Yes (1)
- No (2)

Q9-41 I mentioned my mental illness in my college application essay.

- Yes (1)
- No (2)

Answer If “I mentioned my mental illness in my college application essay. Yes” Is Selected

Q9-42 I mentioned my mental illness in my college application essay (please select all that apply):

- ❑ because it is an important part of me (1)
- ❑ because it makes me different from the typical applicant (2)
- ❑ to show the admissions committee that I have overcome a lot of challenges (3)
- ❑ to explain why I had some academic struggles in high school (4)
- ❑ to explain why I had lots of absences in high school (5)
- ❑ to explain why I went to a therapeutic high school (6)
- ❑ to support my expressed interest in psychology, psychiatry, counseling, medicine, or some other mental health-related academic discipline (7)
- ❑ Other (8)

Answer If “I mentioned my mental illness in my college application essay (please select all that apply): Other” Is Selected

Q9-43 If you chose "Other," above, please write in any additional reasons for disclosing your mental illness history in your college application essay here:

Q9-44 People to whom I have disclosed while in college (please select all that apply):

- ❑ My best friend (1)
- ❑ A small group of friends at my college (2)
- ❑ A small group of friends not from my college (3)
- ❑ A large group of friends at my college (e.g. "everybody I hang with" or "people in my clique") (4)
- ❑ A large group of friends not from my college (5)
- ❑ My boy/girlfriend (6)
- ❑ Certain classmates at my college (7)
- ❑ All of my classmates at my college (8)
- ❑ A trusted faculty member at my college (9)
- ❑ All of my professors at my college (10)
- ❑ A counselor, social worker, or psychologist at my college (11)
- ❑ A coach or other trusted adult at my college (who is not a faculty member or counselor) (12)
- ❑ Members of my sports team, club, or other campus-based group (13)
- ❑ A trusted adult or mentor who works with me outside of college (e.g. clergy person, tutor) (14)
- ❑ Other (15)

Answer If “People to whom I have disclosed while in college (please select all that apply): Other” Is Selected

Q9-45 If "Other" is selected above, please write in your response here:

For the following questions, please type in your response in the space provided.

Q9-46 Are there any other reasons that you have chosen to talk about your mental illness with friends, classmates, boy/girlfriends, college faculty, or other people on campus, or in your life, as a college student? If so, please describe them here:

Q9-47 If this is relevant to you, please describe an instance where you disclosed to someone, or a group, at college, and his/her/their reaction was positive.

Q9-48 If this is relevant to you, please describe an instance where you disclosed to someone, or a group, at college, and his/her/their reaction was negative.

Answer If “Please select the statement, below, that is most accurate for you: In college, I have not disclosed to anyone” Is Selected

Q9-49 What are the reasons that you have decided not to tell anyone at your college about your mental illness? (Please select all that apply.)

- ❑ It's nobody's business (1)
- ❑ I am afraid that people would think less of me (2)
- ❑ I am afraid that I would lose friends (3)
- ❑ I don't want special treatment (4)
- ❑ I don't want to stand out as different. (5)
- ❑ If I told someone, they might not keep it a secret, and other people could find out. (6)
- ❑ It wasn't a big deal. I am a college student just like everyone else. (7)
- ❑ Other (8)

Answer If “What are the reasons that you have decided not to tell anyone at your college about your mental illness? (Please select all that apply.) Other” Is Selected

Q9-50 If you chose "Other," above, please write in any additional reasons that you have chosen to keep your mental health status and experiences completely private.

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**X. This section of the survey is about your mental health recovery.**

**Please complete the following questions by marking whether you *Strongly Disagree, Disagree,* are *Not Sure, Agree*, or *Strongly Agree*.**

Q10-01 I have a desire to succeed.
- ❍ Strongly Disagree (1)
- ❍ Disagree (2)
- ❍ Not Sure (3)
- ❍ Agree (4)
- ❍ Strongly Agree (5)

Q10-02 I have my own plan for how to stay or become well.
- ❍ Strongly Disagree (1)
- ❍ Disagree (2)
- ❍ Not Sure (3)
- ❍ Agree (4)
- ❍ Strongly Agree (5)

Q10-03 I have goals in life that I want to reach.
- ❍ Strongly Disagree (1)
- ❍ Disagree (2)
- ❍ Not Sure (3)
- ❍ Agree (4)
- ❍ Strongly Agree (5)

Q10-04 I believe that I can meet my current personal goals.
- ❍ Strongly Disagree (1)
- ❍ Disagree (2)
- ❍ Not Sure (3)
- ❍ Agree (4)
- ❍ Strongly Agree (5)

Q10-05 I have a purpose in life.
- ❍ Strongly Disagree (1)
- ❍ Disagree (2)
- ❍ Not Sure (3)
- ❍ Agree (4)
- ❍ Strongly Agree (5)

Q10-06 Even when I don’t care about myself, other people do.
- ❍ Strongly Disagree (1)
- ❍ Disagree (2)
- ❍ Not Sure (3)
- ❍ Agree (4)
- ❍ Strongly Agree (5)

Q10-07 Fear doesn't stop me from living the way I want to.
- ❍ Strongly Disagree (1)
- ❍ Disagree (2)
- ❍ Not Sure (3)
- ❍ Agree (4)
- ❍ Strongly Agree (5)

Q10-08 I can handle what happens in my life.
- ❍ Strongly Disagree (1)
- ❍ Disagree (2)
- ❍ Not Sure (3)
- ❍ Agree (4)
- ❍ Strongly Agree (5)

Q10-09 I like myself.
- ❍ Strongly Disagree (1)
- ❍ Disagree (2)
- ❍ Not Sure (3)
- ❍ Agree (4)
- ❍ Strongly Agree (5)

Q10-10 If people really knew me, they would like me.
- ❍ Strongly Disagree (1)
- ❍ Disagree (2)
- ❍ Not Sure (3)
- ❍ Agree (4)
- ❍ Strongly Agree (5)

Q10-11 I have an idea of who I want to become.
- ❍ Strongly Disagree (1)
- ❍ Disagree (2)
- ❍ Not Sure (3)
- ❍ Agree (4)
- ❍ Strongly Agree (5)

Q10-12 Something good will eventually happen.
- ❍ Strongly Disagree (1)
- ❍ Disagree (2)
- ❍ Not Sure (3)
- ❍ Agree (4)
- ❍ Strongly Agree (5)

Q10-13 I'm hopeful about my future.
- ❍ Strongly Disagree (1)
- ❍ Disagree (2)
- ❍ Not Sure (3)
- ❍ Agree (4)
- ❍ Strongly Agree (5)

Q10-14 I continue to have new interests.
- ❍ Strongly Disagree (1)
- ❍ Disagree (2)
- ❍ Not Sure (3)
- ❍ Agree (4)
- ❍ Strongly Agree (5)

Q10-15 Coping with my mental illness is no longer the main focus of my life.
- ❍ Strongly Disagree (1)
- ❍ Disagree (2)
- ❍ Not Sure (3)
- ❍ Agree (4)
- ❍ Strongly Agree (5)

Q10-16 My symptoms interfere less and less with my life.
- ❍ Strongly Disagree (1)
- ❍ Disagree (2)
- ❍ Not Sure (3)
- ❍ Agree (4)
- ❍ Strongly Agree (5)

Q10-16A My symptoms seem to be a problem for shorter periods of time each time they occur.
- ❍ Strongly Disagree (1)
- ❍ Disagree (2)
- ❍ Not Sure (3)
- ❍ Agree (4)
- ❍ Strongly Agree (5)

Q10-17 I know when to ask for help.
- ❍ Strongly Disagree (1)
- ❍ Disagree (2)
- ❍ Not Sure (3)
- ❍ Agree (4)
- ❍ Strongly Agree (5)

Q10-18 I am willing to ask for help.
- ❍ Strongly Disagree (1)
- ❍ Disagree (2)
- ❍ Not Sure (3)
- ❍ Agree (4)
- ❍ Strongly Agree (5)

Q10-19 I ask for help when I need it.
- ❍ Strongly Disagree (1)
- ❍ Disagree (2)
- ❍ Not Sure (3)
- ❍ Agree (4)
- ❍ Strongly Agree (5)

Q10-20 I can handle stress.
- ❍ Strongly Disagree (1)
- ❍ Disagree (2)
- ❍ Not Sure (3)
- ❍ Agree (4)
- ❍ Strongly Agree (5)

Q10-21 I have people I can count on.
- ❍ Strongly Disagree (1)
- ❍ Disagree (2)
- ❍ Not Sure (3)
- ❍ Agree (4)
- ❍ Strongly Agree (5)

Q10-22 Even when I don’t believe in myself, other people do.
- ❍ Strongly Disagree (1)
- ❍ Disagree (2)
- ❍ Not Sure (3)
- ❍ Agree (4)
- ❍ Strongly Agree (5)

Q10-23 It is important to have a variety of friends.
- ❍ Strongly Disagree (1)
- ❍ Disagree (2)
- ❍ Not Sure (3)
- ❍ Agree (4)
- ❍ Strongly Agree (5)

**XII. End of Survey**

Q11-1 Is there anything else that you would like to add about your experience as a student with a mental illness? If so, please feel free to write more here:

Q11-2 You have reached the end of the survey.

Thank you very much for taking the time to complete it! Please feel free to share the URL to link to this survey, below, with friends who are also college students with mental illness. The more respondents we have, the better!

https://upenn.co1.qualtrics.com/SE/?SID=SV_1BnG2d6e3vXIv6l

And if you would like to be entered into a lottery to win one of three $100 Amazon gift cards, please write your email in the space below. Your contact info. will be kept confidential, and will only be used for the purpose of contacting you if your email is drawn as a gift card winner after Dec. 31, 2015. (We need to be able to contact winners and send their gift cards electronically.)

Thank you again for all of your help!
Sincerely,
Laura Murray

email: lamurray@gse.upenn.edu

APPENDIX L

## I. General Mental Health Resources for Youth, Young Adults, and their Families

**BeyondBlue** – www.beyondblue.org.au (Australia)

> *"beyondblue* is working to reduce the impact of depression and anxiety in the community by raising awareness and understanding, empowering people to seek help, and supporting recovery, management and resilience."

**Headspace -** http://headspace.org.au

> Created by National Youth Mental Health Foundation, Australia

**LETS** – www.lets.org

> Non-profit supporting student-initiated "Let's Erase the Stigma" clubs in U.S. high schools
>
> "A youth-led, club-based social movement dedicated to erasing the shame, fear, and isolation kids feel talking about personal problems and asking for help"

**Mental Health America** (MHA) - www.mentalhealthamerica.net

**MindEd** – https://www.minded.org.uk/

> "e-learning to support young healthy minds"
>
> "MindEd is a free educational resource on children and young people's mental health for all adults."
>
> Online learning modules listed here: www.minded.org.uk/mod/page/view.php?id=1259
>
> Overview of online content here: www.minded.org.uk/local/curricula/view

**Mind Matters** - http://www.mindmatters.edu.au/default.asp (Australia)

> "MindMatters is a national mental health initiative for secondary schools funded by the Australian Government Department of Health and Ageing."
>
> "MindMatters is a resource and professional development initiative supporting Australian secondary schools in promoting and protecting the mental health, and social and emotional wellbeing of all the members of school communities."
>
> Check out their online module "Leading a whol school approach for mental health" here: http://www.mindmatters.edu.au/professional_development/online_module_leadership.html

**National Alliance on Mental Health** (NAMI) - www.nami.org

**Pathways to Positive Futures Research and Training Center** (RTC)

www.pathwaysrtc.pdx.edu

**Suicide Prevention Resource Center** (SPRC) – www.sprc.org

**UMASS Medical School – Transitions Research and Training Center** (RTC)

www.umass.edu/transitionsrtc

**Voice for hope** – www.voices4hope.net

Voices4Hope is a place for teenagers and young adults with mental health conditions to resources and stigma busting information that can help us lead happy and independent lives.

This website was created and is maintained by young adults with mental health conditions at the Transitions Research and Training Center (RTC).

**What a Difference a Friend Makes** - http://store.samhsa.gov/product/SMA07-4265

A "Campaign for Mental Health Recovery" by SAMHSA (federal Substance Abuse and Mental Health Services Administration)

"Encourages young adults to support a friend living with mental illness in the recovery process. Defines mental illness and recovery; offers strategies for how to respond to a friend; dispels myths; and lists suggestions for supporting recovery."

*You can order this publication for free

**Young People in Recovery** – www.youngpeopleinrecovery.org

**Youth MOVE** – www.youthmovenational.org

"Motivating Others Through Voices of Experience"

"Youth M.O.V.E National is a youth led national organization devoted to improving services and systems that support positive growth and development by uniting the voices of individuals who have lived experience in various systems including mental health, juvenile justice, education, and child welfare."

## II. Resources for K-12 Schools, Administrators, Teachers, and Counselors

**American Psychological Association** (APA) – www.apa.org/education/k12/curricular-materials.aspx

Their *Center for Psychology in Schools and Education* (CPSE) curricular materials aide PK-12 teachers in using psychological findings to support/improve their work with students

**Breaking the Silence: Teaching the next generation about mental illness**

www.btslessonplans.org/

Lesson plans for educators to teach middle and high school students about mental illness and recovery. Originally developed by the NAMI (National Alliance on Mental Illness) chapter in Queens/Nassau County, NY

**Brookline Resilient Youth Team (BRYT)** – www.brooklinecenter.org/bryt

A program to help students transition back to school after a psychiatric hospitalization

**Center for School Mental Health** (Univ of Maryland) – csmh.umaryland.edu

"The mission of the CSMH is to strengthen policies and programs in school mental health to improve learning and promote success for America's youth."

**City Connects**

http://www.bc.edu/schools/lsoe/cityconnects/

"Out-of-school factors can significantly impact students' readiness to learn and thrive in school, especially in high-poverty urban districts. Hunger, a stay in a homeless shelter, persistent medical problems, or simply a lack of access to enriching activities in arts and sports can affect a student's life in school. City Connects provides an organized way for schools to address these factors. Our system of student support involves every classroom teacher, leverages resources in the community, ensures that all students receive the supports they need, and has strong positive results."

"Our school-based model identifies the strengths and needs of every student and links each child to a tailored set of intervention, prevention, and enrichment services in the school or community. We efficiently and cost-effectively address the in- and out-of-school factors that impact students' academic, social-emotional, family, and physical well-being."

"We help students come to school ready to engage and learn. Each student's ability to thrive in the classroom depends on a unique set of academic, social/emotional, health, and family-related factors. We address each child's strengths and needs across these four dimensions."

**Regional K-12 Student Mental Health Initiative -** www.regionalK12smhi.org

A clearinghouse of resources and regional best practices provided to assist California county offices of education, districts and schools to develop and implement effective programs and services that promote the mental health and wellness of students in grades K-8, with linkages to preschool and grades 9-12.

**SAMHSA** (Substance Abuse and Mental Health Services Administration)

http://promoteacceptance.samhsa.gov/topic/education/default.aspx

SAMHSA's Resource Center to Promote Acceptance, Dignity and Social Inclusion Associated with Mental Health (ADS Center)

*Education*

"This section offers information for educators and students on the role that education plays in mental health awareness and recovery. Grade-school children with serious emotional disturbances have the highest rates of school failure because of the discrimination and stigma associated with these disorders. Fifty

percent of these students drop out of high school, compared to 30 percent of all students with disabilities. The situation gets worse as the students get older: college-age students are especially vulnerable to mental illness; many psychiatric disorders first emerge in the late teens or early twenties.

Not only do students with mental health problems experience difficulties but their teachers do, too. It can be frustrating to teach such students who have mental illnesses not only because of their difficulties in learning but because of the impact of their behaviors on the rest of the class.

Mental health awareness by everyone in the classroom may increase acceptance and understanding of people with mental illnesses, decrease the negative attitudes that are oftentimes attached to mental health problems, and lead to treatment for youth with mental health disorders."

School Materials for a Mental Health Friendly Classroom: Training Package
*Barriers for Learning; Social and Emotional Factors that Enhance Secondary Education*

*You can download this toolkit for free here:

http://www.promoteacceptance.samhsa.gov/publications/school_modules.aspx

"Eliminating Barriers for Learning is a packaged continuing education program for secondary school teachers and staff that focuses on mental health issues in the classroom. Its overall aim is to help eliminate barriers to learning by understanding and addressing mental health issues in the school environment. Developed by the Substance Abuse and Mental Health Services Administration, part of the U.S. Department of Health and Human Services, it offers information on adolescent social-emotional wellness and provides specific skill-based techniques for classroom use. It aims to—

- Increase knowledge of adolescent mental health, including risks and protective factors;
- Show teachers and staff how to develop strategies to help students who need additional support;
- Suggest ways to promote a mentally healthy learning environment through instructional techniques that take into account individual styles of learning and classroom climate; and
- Help teachers and staff identify school and community resources and partnerships to promote youth mental health."

**StopBullying.gov** - http://www.stopbullying.gov/what-you-can-do/parents/index.html

This site is managed by the Federal government for the purpose of preventing bullying. There is a section just for parents that provides information on what bullying is, what actions to take, and tips for how to talk to your child if you suspect he or she is being bullied.

**Teen Mental Health**

www.teenmentalhealth.org

Stan Kutcher, M.D. and his colleagues (Canada) – psychiatrist doing work with teens and educators to promote youth mental health and wellness

*See the 6 modules for grade 9 & 10 students here:

http://teenmentalhealth.org/curriculum/student-modules/

**The Science of Mental Illness** - http://science.education.nih.gov/customers.nsf/msmental

Curriculum supplement for middle school science classes (created by NIMH)

**UCLA School Mental Health Project** - http://smhp.psych.ucla.edu/

**Youth Mental Health First Aid** (Youth MHFA)

www.thenationalcouncil.org/about/mental-health-first-aidhealthymindsphilly.org/mental-health- first-aid.aspx

For adults who work with youth

**III. Resources for College Students and Institutions of Higher Ed.**

**Active Minds** – www.activeminds.org

National U.S. non-profit supporting college-based chapters to promote mental health education, advocacy, and awareness.

Their mission: "Change the conversation about mental health on college campuses"

**Association for University and College Counseling Center Directors (AUCCCD)**

www,aucccd.org

"The mission of the Association for University and College Counseling Center Directors (AUCCCD) is to assist college/university directors in providing effective leadership and management of their centers, in accord with the professional principles and standards with special attention to issues of diversity and multiculturalism. AUCCCD promotes the awareness of student mental health and development issues in higher education through research, advocacy, education, and training provided to members, professional organizations, and the public."

**Center for Collegiate Mental Health** (at Penn State University) - http://ccmh.psu.edu/

"CCMH is a multidisciplinary, member-driven, practice research network that is focused on providing accurate and up-to-date information on the mental health of today's college students. CCMH strives to connect practice, research, and technology to benefit students, mental health providers, administrators, researchers, and the public.

The collaborative efforts of more than 350 college counseling centers and supportive organizations have enabled for CCMH to build one of the nation's largest clinical aggregate databases and to manage and develop clinical tools using cutting-edge technologies and nationally representative clinical norms."

**Healthy Minds Network** - http://healthymindsnetwork.org/

(At University of Michigan)

"**The Healthy Minds Network for Research on Adolescent and Young Adult Mental Health** (HMN) is dedicated to improving the mental and emotional well-being of young people through innovative, multidisciplinary scholarship. HMN addresses the connection between the mental health of adolescents and young adults and their health behaviors, physical health, and social, educational, and economic outcomes."
*Note that HMN is beinh the longitudinal "Healthy Minds Study" (HMS), is an annual web-based survey study examining mental health, service utilization, and related issues among undergraduate and graduate students. Since its national launch in 2007, HMS has been fielded at over 100 colleges and universities, with over 100,000 survey respondents.

> "HMS is one of the only annual surveys of college and university populations that focuses exclusively on mental health and related issues, allowing for substantial detail in this area. The study has a special emphasis on understanding service utilization and help-seeking behavior, including factors such as stigma, knowledge, and the role of peers and other potential gatekeepers. The study also allows colleges and universities to examine how mental health symptoms predict academic outcomes (GPA and retention), which is translated into an economic case for mental health services and programs."

**NAMI on Campus**

https://www.nami.org/Get-Involved/NAMI-on-Campus/NAMI-on-Campus-Clubs

"NAMI on Campus clubs are student-led, student-run mental health organizations on college campuses. NAMI on Campus clubs:

- Raise mental health awareness with fairs, walks and candlelit vigils.
- Educate the campus with presentations, guest speakers and student panels.
- Advocate for improved mental health services and policies on campus.
- Support peers with signature NAMI programs and training from NAMI State Organizations and Affiliates."

**National Research Consortium of Counseling Centers in Higher Education** (at Univ of Texas, Austin) - www.cmhc.utexas.edu/rc_project6.html

Conducts large-scale research studies on mental health issues among college students. Participation in the Research Consortium is open to any U.S. institution of higher education, and membership in the Research Consortium changes for each study that is conducted. The Consortium's most recent study (2011), on the nature of distress, suicidality, and student coping involved participants from 74 U.S. colleges and universities, establishing the largest dataset of In-depth college student suicidal behavior and coping.

**Transition Year: Your source for emotional health at college** - http://transitionyear.org/

"Whether you are looking for tips on picking a school that is the best fit, interested in finding ways to manage stress once on campus, or want guidance in making a smooth transition for a student dealing with an issue like depression, this site has the information and resources you need. The Transition Year is an online resource center to help parents and students focus on emotional health before, during and after the college transition. It's common to assume that the major obstacle in adjusting to campus life will be academic. However, research shows that emotional issues are most likely to interfere with success at college. Transition Year helps you prepare."

**The Jed Foundation** – www.jedfoundation.org

Their goal: promote emotional health and prevent suicide among college students

"As the nation's leading organization working to promote emotional health and prevent suicide among college students, The Jed Foundation is protecting the mental health of students across the country. With your support, we will continue to lead the way and protect the potential of tomorrow's leaders."

**ULifeline** – www.ulifeline.org/jhu/

"Your online resource for college mental health"

"ULifeline is a comprehensive, confidential, online resource center where you can feel comfortable searching for the information you need and want regarding mental and emotional health…Find your school to see campus specific resources and information"
*Note that ULifeline is a project of The Jed Foundation

## IV. Mental Health Stigma-busting Organizations and Initiatives

**Bring Change to Mind** – www.bringchange2mind.org

"Working to end the stigma and discrimination of mental illness"

**Project Lets** (Let's Erase the Stigma) – www.letserasethestigma.com

**Time to Change** (UK) - www.time-to-change.org.uk

Campaign to "end mental health stigma" out of Britian

## V. Suicide Prevention

**American Foundation for Suicide Prevention (AFSP)** – www.afsp.org

"Our mission: Save lives and bring hope to those affected by suicide"

*Note their new (as of May, 2015) "Signs Matter: Early Detection" (online suicide prevention training for K-12 educators):

www.afsp.org/preventing-suicide/our-education-and-prevention-programs/programs-for-professionals/signs-matter-early-detection

**JED Foundation** – www.jedfoundation.org

(See above)

**National Suicide Prevention Lifeline** – www.suicidepreventionlifeline.org

1-800-273-8255 or 1-800-273-TALK

**Substance Abuse and Mental Health Services Administration (SAMHSA)**

Preventing Suicide: A Toolkit for High Schools

http://store.samhsa.gov/product/Preventing-Suicide-A-Toolkit-for-High-Schools/SMA12-4669

*You can download the toolkit for free

"Assists high schools and school districts in designing and implementing strategies to prevent suicide and promote behavioral health. Includes tools to implement a multi-faceted suicide prevention program that responds to the needs and cultures of students."

**Suicide Prevention Resource Center (SPRC)** – www.sprc.org

## VI. Laws Related to Disability and Accommodations

**Americans with Disabilities Act (ADA)** - www.ada.gov

"The Americans with Disabilities Act (ADA) was signed into law on July 26, 1990, by President George H.W. Bush. The ADA is one of America's most comprehensive pieces of civil rights legislation that prohibits discrimination and guarantees that people with disabilities have the same opportunities as everyone else to participate in the mainstream of American life -- to enjoy employment opportunities, to purchase goods and services, and to participate in State and local government programs and services. Modeled after the Civil Rights Act of 1964, which prohibits discrimination on the basis of race, color, religion, sex, or national origin – and Section 504 of the Rehabilitation Act of 1973 -- the ADA is an "equal opportunity" law for people with disabilities."

**Individuals with Disabilities Education Act (IDEA)** - http://idea.ed.gov/

"The Individuals with Disabilities Education Act (IDEA) is a law ensuring services to children with disabilities throughout the nation. IDEA governs how states and public agencies provide early intervention, special education and related services to more than 6.5 million eligible infants, toddlers, children and youth with disabilities."

Also see info on IDEA on the National Center for Learning Disabilities site here:

http://www.ncld.org/disability-advocacy/learn-ld-laws/idea/what-is-idea

"The Individuals with Disabilities Education Act (IDEA) is the nation's federal special education law that ensures public schools serve the educational needs of students with disabilities. IDEA requires that schools provide special education services to eligible students as outlined in a student's Individualized Education Program (IEP). IDEA also provides very specific requirements to guarantee a Free Appropriate Public Education (FAPE) for students with disabilities in the least restrictive environment (LRE). FAPE and LRE are the protected rights of every eligible child, in all fifty states and U.S. Territories."

**Section 504 of the Rehabilitation Act of 1973**

www.hhs.gov/ocr/civilrights/resources/factsheets/504.pdf

(Fact Sheet on Section 504 available for download at above URL)

"Section 504 protects qualified individuals with disabilities. Under this law, individuals with disabilities are defined as persons with a physical or mental impairment which substantially limits one or more major life activities. People who have a history of, or who are regarded as having a physical or mental impairment that substantially limits one or more major life activities, are also covered. Major life activities include caring for one's self, walking, seeing, hearing, speaking, breathing, working, performing manual tasks, and learning. Some examples of impairments which may substantially limit major life activities, even with the help of medication or aids/devices, are: AIDS, alcoholism, blindness or visual impairment, cancer, deafness or hearing impairment, diabetes, drug addiction, heart disease, and mental illness."

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